

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-039457**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3000

**FILED NOV 8 1961**

AMENDED

DATE AMENDED

INSTEAD OF

THEY SHOULD BE MADE

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>Normandy</u>	
Length of stay in 1b- <u>5-Mon.</u>		"Inside Limits" Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>7026 Nat'l. Bridge Immaculate Heart Convent</u>		d. STREET ADDRESS (If outside, give location) <u>401 North Hills Drive</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Byrne</u>			4. DATE OF DEATH Month <u>October</u> Day <u>25th.</u> Year <u>1961</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/1881</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HR. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done) <u>Retired, Secty. Wabash R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>    </u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Laughlin Byrne</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Walsh</u>		14. NAME OF HUSBAND OR WIFE <u>    </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? ( <u>no</u> , or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Mr. Frank Lee, Atty., 722 Chestnut Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>    </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>    </u> s.m. <u>    </u> p.m. <u>    </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Aug. '61</u> to <u>10-25-61</u> and last saw him alive on <u>9-14-61</u> Death occurred at <u>7:46 am.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ann Huggins, M.D.</u>		22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>10-26-61</u>
23a. BURIAL, CREMATION, OR REMOVAL SOCIETY <u>REMOVAL</u>		23b. DATE <u>10/28/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>		25. DATE RECD. BY LOCAL REG. <u>10-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
ADDRESS <u>840 Lindell Blvd.</u>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4699

P. O. Address 3840 Lander

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.