

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039624
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

HOW TWO SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2893

FILED OCT 24 1961

1. PLACE OF DEATH
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights Length of stay in 1b YRS c. CITY OR TOWN Richmond Heights Inside Limits Yes No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital Inside Limits Yes No d. STREET ADDRESS (If outside, give location) 7779 Gissler Ave., Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First CLARENCE Middle J. Last NOLAN 4. DATE OF DEATH Month Oct. Day 12, Year 1961

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10-22-1906 9. AGE (last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HR
Month 11 Day 20 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A. 10b. KIND OF BUSINESS OR INDUSTRY Witte Haw. Co. 11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME John Nolan 13b. MOTHER'S MAIDEN NAME Mary Craney 14. NAME OF HUSBAND OR WIFE Mary Jane Nolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 17. INFORMANT Address Mary Jane Nolan 7779 Gissler Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subacute Bacterial Endocarditis
DUE TO (c) _____
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Aug 15 1961 to Oct 12 - 61 and last saw ^{her}him alive on Oct 12 1961
Death occurred at 7:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clarence J. Oct 22b. ADDRESS 2816 Sutton Ave 22c. DATE SIGNED 10/14/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Reburial 23b. DATE Oct. 16, 1961 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS A. H. Bocklage 6536 Clayton Rd. 25. DATE RECD. BY LOCAL REG. 10-14-61 26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

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 Clair R. Radwell

Licensed Embalmer No. 4077

P. O. Address St Louis

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.