

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042976
STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11145**

FILED DEC 12 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 12 Weeks | c. CITY OR TOWN Pine Lawn Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4222 Beachwood Ave., 20 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last TREACY | | | 4. DATE OF DEATH Nov. 29th, 1961 Month Day Year | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-22-1905 | 9. AGE (last birthday) 56 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Faith Hospital | 11. BIRTHPLACE (City and state or country) County Kilkenny, Ireland | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Denis Treacy | | 13b. MOTHER'S MAIDEN NAME Catherine Roach | | 14. NAME OF HUSBAND OR WIFE Ursula Treacy | |

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| 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 Ursula Treacy, 4222 Beachwood Ave., 20. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease | | INTERVAL BETWEEN ONSET AND DEATH 11 mo. |
| DUE TO (b) 201X | | |
| DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hemorrhagic Pancreatitis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 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 |
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21. I attended the deceased from **Jan 20, 1961** to **Nov 29, 1961** and last saw ^{her}him alive on **Nov 29, 1961**
Death occurred at **6:10 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE M. A. Cassel, M.D. (Degree or title) | 22b. ADDRESS 3400 N. Kingshighway | 22c. DATE SIGNED 11-30-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12-2-61 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
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| 24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri. | 25. DATE RECD. BY LOCAL REG. NOV 30 1961 | 26. REGISTRAR'S SIGNATURE Lead Smith, M.D. |
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DATE AMENDED
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 Robert E. Mahlema

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo.

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.