

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004310

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1231**

STATE FILE NUMBER

AMENDED

FILED FEB 7 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>3 1/2-wks</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5322 Savoy Court</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>Ann</b> Last <b>O'ROURKE</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>27</b> Year <b>1962</b>	
--	--	--	---	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/87</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	-----------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeping</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	---	--	--

13a. FATHER'S NAME <b>----- Williams</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Daniel A. O'Rourke</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>R.E. O'ROURKE - 5322 Savoy Ct.</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>		<b>48 HRS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	<b>10 YRS</b>
	DUE TO (c) <b>4200</b>	

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 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
--	--	------------------------------	--------	-------

21. I attended the deceased from **JANUARY 2, 1962** to **JANUARY 27, 1962** and last saw her **alive** on **JANUARY 27, 1962**  
Death occurred at **11:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>F. R. Bradley M.D.</i>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>1/28/62</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 31, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 29 1962</b>	26. REGISTRAR'S SIGNATURE <i>Coal Smith M.D.</i>
--	--	---

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**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 Harmer M. Butts

Licensed Embalmer No. 4375

P. O. Address St. Louis 23, 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.