

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008130

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2752

STATE FILE NUMBER

FILED MAR 15 1962

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		Length of stay in 1b 6-Years	c. CITY OR TOWN St Louis Mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1610 S. Grand Ave
3. NAME OF DECEASED (Type or print) First Middle Last Sister Albertine Grehan		4. DATE OF DEATH Month Day Year 3 12 62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 82
11. BIRTHPLACE (City and state or country) Ireland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Michael Grehan		13b. MOTHER'S MAIDEN NAME Mary Ann Dunne	14. NAME OF HUSBAND OR WIFE Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Sister Tarcisia 2800 Normandy Dr
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Heart Disease secondary</i>			INTERVAL BETWEEN ONSET AND DEATH <i>several yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cardio-Renal Vascular disease</i>			<i>several yrs</i>
DUE TO (c) <i>Uremia</i>			<i>442x about 2-3 weeks</i>
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 <i>3-2-60</i> to <i>3-12-62</i> and last saw her/him alive on <i>3-9-62</i> Death occurred at <i>1252 Hwy 3-12-62</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John F Flynn BMD</i> (Degree or title)		22b. ADDRESS <i>1715 So 39th St Kansas</i>	22c. DATE SIGNED <i>3-12-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3-13-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Incarnate Word</i>	23d. LOCATION (City, town, or county) <i>Normandy Mo</i> (State)
24. FUNERAL DIRECTOR <i>Arthur J. Donnelly 3810 Lindell Blvd</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 12 1962</i>	26. REGISTRAR'S SIGNATURE <i>Robert Smith, M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

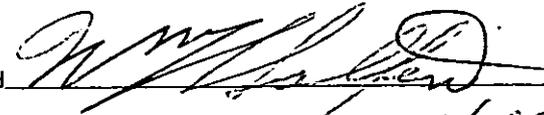
THE JOHN T. FLYNN
1715 S. 39th St
W 1-2078
1-3330

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 Lincoln St

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.