

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-008723
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2645**

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 15 1962

VS 300 Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in lb 5 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4408 Wabash				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace T. Shea						4. DATE OF DEATH Month Day Year March 7, 1962					
5. SEX F		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-6-1876		9. AGE (last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Lawrence, Massachusetts		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME William H. Shea				13b. MOTHER'S MAIDEN NAME Mary Ann Riordan				14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Vivian K. Sarli 4408 Wabash					
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>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>334X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 8 weeks <u>4 1/2</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 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 <u>2-1-62</u> , to <u>3-6-62</u> and last saw her alive on <u>3-6-62</u> Death occurred at <u>2 00 Am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>John J. Onley M.D.</u> (Degree or title)						22b. ADDRESS <u>5203 Chippewa St. Louis Mo</u>			22c. DATE SIGNED <u>3-7-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <u>3-9-62</u>		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY				ADDRESS SAM		25. DATE RECD. BY LOCAL REG. MAR 8 1962		26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>			

Bill 4 years

Dr. John J. Inkley
5203 Chippewa
PL. 2-0632

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 John J. Inkley
Licensed Embalmer No. 4194
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.