

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009306
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 505

FILED FEB 23 1962

VS 300
Rev. 4/59
1 40-02
2 9013
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4 0
5 1
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7 0
8 2
9 420.1
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11
12 45-0
13

DATE AMENDED
INSTEAD OF
SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CO. HOSPITAL</u>		Length of stay in 1b HOURS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u> c. CITY OR TOWN <u>FLORISSANT</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>132 GRAHAM RD.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL FRANCIS MEEHAN</u>			4. DATE OF DEATH Month Day Year <u>2 9 1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 31, 1919</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL OFFICE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>DAVID MEEHAN</u>		13b. MOTHER'S MAIDEN NAME <u>KATHERINE GALLAGHER</u>		14. NAME OF HUSBAND OR WIFE <u>BERNICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES UN-K</u>			17. INFORMANT <u>BERNICE MEEHAN</u> Address <u>132 GRAHAM RD. FLORISSANT, MO</u>		
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>Ventricular fibrillation</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)	
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>2-9-1962</u> to <u>2-9-1962</u> and last saw him alive on <u>2-9-1962</u> Death occurred at <u>343 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert L. Howe MD</u> (Degree or title)		22b. ADDRESS <u>601 So. Brentwood Blvd.</u>		22c. DATE SIGNED <u>2-9-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2-12-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>	
24. FUNERAL DIRECTOR <u>The Florissant Mortuary, Florissant, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-11-62</u>		26. REGISTRAR'S SIGNATURE <u>J. G. Murphy M.D.</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

MAR 1 1962

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 *Gene S. Matthews*

Licensed Embalmer No. 4966

P. O. Address. FLORISSANT, 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.