

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035998

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8818

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. FILED SEP 17 1962 a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3457 WYOMING</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3457 WYOMING</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>H.</u> Last <u>CAHILL</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>10</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR, OR RACE <u>WHITE</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>NOV 5, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. JOSEPH HOSP</u>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		9. AGE (last birthday) <u>68</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
13a. FATHER'S NAME <u>HOWARD CAHILL</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Deloras Cahill</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W W I</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Deloras Cahill 3457 WYOMING</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thromboses</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause (b) last. <u>Due to (b) Deputy Comm 9-12-62 4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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>March, 1962</u> to <u>Sept 9, 1962</u> and last saw him alive on <u>Jan 16, 1962</u> Death occurred at <u>3:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles E. Hoganamp, M.D.</u>		22b. ADDRESS <u>135 W. Adams Ave. Kirkwood, Mo.</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT 12, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. Louis Co Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Ratis 2906 Brown</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 12 1962</u>	26. REGISTRAR'S SIGNATURE <u>Ed Smith, M.D.</u>

Dr. C. Hogenkamp
135 W. Adams
Yo 5-5868

fill 4 rows
10-4 9m

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 J. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address. 2906 Graves

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.