

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040143

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10125**

STATE FILE NUMBER

FILED NOV 1 1962

VS 300  
Rev. 4/59

1

2 **209**

3

4 **1**

5 **2**

6

7 **0**

8 **2**

9

10

11

12 **90-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

90  
Dated, - date - large - bowel

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4540 Red Bud</b>		d. STREET ADDRESS (If outside, give location) <b>4540 Red Bud Ave.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle Last <b>Delaney</b>			4. DATE OF DEATH Month <b>10</b> Day <b>22</b> Year <b>62</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>6/18/02</b>
9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Daniel Austin</b>	
13b. MOTHER'S MAIDEN NAME <b>Nellie Carroll</b>		14. NAME OF HUSBAND OR WIFE <b>Lloyd Delaney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dan Delaney</b>		Address <b>4540 Red. Bud</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTESTINAL OBSTRUCTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
DUE TO (b) <b>RECURRENT CARCINOMA</b>			
DUE TO (c) <b>153.8</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PERNICIOUS ANEMIA, MAL-NUTRITION</b>			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 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 <b>Aug 15</b> to <b>Oct 22-62</b> and last saw her him alive on <b>Oct 11, 62</b> Death occurred at <b>8:30 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Julio Montes-de-Oca</b> (Degree or title) <i>J. Montes-de-Oca, MD</i>		22b. ADDRESS <b>950 Francis Pl. (Clayton)</b>	
22c. DATE SIGNED <b>Oct 23, 62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/25/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		23e. STATE	
24. FUNERAL DIRECTOR <b>Robert D. Kinealy</b>		ADDRESS <b>2228 St. Louis Ave</b>	
25. DATE RECD. BY LOCAL REG. <b>OCT 23 1962</b>		REGISTRAR'S SIGNATURE <i>Joan Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 Herbert J. Han Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 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.