

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048739

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12041

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12041

FILED DEC 21 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>21</u>				
3				
4 <u>1</u>				
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9	SHOULD READ	BY AFFIDAVIT OF		
10				
11 <u>000</u>				
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<u>74</u>				

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 Weeks</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4465 Laclede Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Shea</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> , Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Ireland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>David Shea</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Fitzgerald</u>		14. NAME OF HUSBAND OR WIFE <u>Single</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Alice Barry 4465 Laclede Ave.</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>Broncho-Pneumonia -</u> DUE TO (b) <u>9030</u> DUE TO (c) <u>4:20</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease - due to long</u>			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 checked="" 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.) <u>Fallen in bathroom - striking chest - fracture</u>	
20c. TIME OF INJURY Hour <u>11</u> Month, Day, Year <u>11 29 62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		
20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>		COUNTY <u>Mo.</u>	STATE
21. I attended the deceased from <u>6:30 - 6:30</u> to <u>12-14-62</u> and last saw her alive on <u>12-13-62</u> Death occurred at <u>6:30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Deplina McMahon, M.D.</u>		22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>12-15-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/17/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Collier Mortuary, St. Ann, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 15 1962</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

EX-101 1 8 1970 0311 11

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann 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.