

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004074

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 42

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH 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 <u>11 days</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>3225 Montgomery</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle Last <u>Scannell</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>63</u>	
5. SEX <u>Male</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>6-22-78</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</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>Michael Scannell</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Fitzgerald</u>	
14. NAME OF HUSBAND OR WIFE <u>Michael O'Keefe</u>		Address <u>6829 Crest U. City, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Michael O'Keefe</u>		Address <u>6829 Crest U. City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suspected pulmonary embolus</u> DUE TO (b) <u>stasis ulcer of right leg</u> DUE TO (c) <u>460x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>day of death</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>			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 AN 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 s.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>12-21-62</u> to <u>1-2-63</u> and last saw her/him alive on <u>1-2-63</u> Death occurred at <u>6:07 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>M. Stingerhood M.D.</u>	
22b. ADDRESS <u>5600 Arsenal Street</u>		22c. DATE SIGNED <u>1-3-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-4-63</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 <u>Kriegshauser West</u>		ADDRESS <u>9450 Olive St. Rd.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 3 1963</u>
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 R.W. Storransd

Licensed Embalmer No. 4007

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.