

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008490

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1390

STATE FILE NUMBER

FILED FEB 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 15 Days	c. CITY OR TOWN Richmond Heights
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7314 Dale Avenue
3. NAME OF DECEASED (Type or print) First Middle Last DELIA CRONIN		4. DATE OF DEATH Month Day Year February 7, 1963	
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-7-90
9. AGE (last birthday) 77		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Ireland
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME James Rogers	
13b. MOTHER'S MAIDEN NAME Sarah Heneghan		14. NAME OF HUSBAND OR WIFE William D. Cronin (Dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of No		16. SOCIAL SECURITY NO.	
17. INFORMANT William R. Cronin, 7314 Dale Avn.		Address.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
DUE TO (b) <i>Metastatic carcinoma liver</i>		6 mos	
DUE TO (c) <i>Carcinoma of breast</i>		6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic heart disease</i>		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.) 170x	
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 <i>9/23/62</i> to <i>2/17/63</i> and last saw her <i>live on 2/17/63</i> Death occurred at <i>9:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>[Signature]</i>	
22b. ADDRESS <i>52 Mayland place</i>		22c. DATE SIGNED <i>2/8/63</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-11-63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR <i>Arthur P. Donnelly</i>		ADDRESS 3810 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. FEB 8 1963
26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Sam Prange
52 Maryland Plaza
Delia Loren

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 W. S. S. S.

Licensed Embalmer No. 4699

P. O. Address 3840

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.