

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014132

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 750 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH MAR 18 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nirkwood</u>	a. STATE <u>MO</u>	b. COUNTY <u>St. Louis</u>
Length of stay in 1b <u>2 wks.</u>		c. CITY OR TOWN <u>Pacific</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph</u>		d. STREET ADDRESS <u>RR 1 qmic. of Pacific</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Devine</u>			4. DATE OF DEATH Month Day Year <u>Mar. 3. 1963</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1869</u>	9. AGE (last birthday) <u>94</u>	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) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Pacific MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>James Edward Devine</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine McNamee</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine Devine (deceased)</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>	16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Katherine Dailey Allenton, Mo.</u>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>	DUE TO (b) <u>Arteriosclerosis hyper-</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>senile heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General arterio-sclerosis of the brain</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 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 a.m. p.m.	Month, Day, Year	

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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Jan - 20 63 - March 3-63</u> and last saw him alive on <u>March 3-63</u>		Death occurred at <u>5 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Ink or title) <u>[Signature] MD</u>	22b. ADDRESS <u>Pacific MO</u>	22c. DATE SIGNED <u>3/4/63</u>
---	--------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Mar 6, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Budgets</u>	23d. LOCATION (City, town, or county) (State) <u>Pacific MO</u>
--	------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Mrs. John R. Shultz Pacific MO</u>	25. DATE RECD. BY LOCAL REG. <u>3-4-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

4603

20360

3

4 0

5 2

6

7 0

8 0

94200

10

11

12440

13

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

MAY 28 1963

MAR 20 1964

JUN 24 1963

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

Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.