

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017505

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

3426

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

FILED APR 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri COUNTY St

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb D.O.A.

c. CITY OR TOWN St. Louis Inside Limits Yes # No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital # 1 Inside Limits Yes # No

d. STREET ADDRESS (If outside, give location) 1445A (Rear) Clinton Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Anna Connelly

4. DATE OF DEATH Month Day Year March 22, 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 2/6/1905 9. AGE (last birthday) 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Divorced

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No No

16. SOCIAL SECURITY NO. 17. INFORMANT Address Robert W. Connelly 8446 Betty Lee

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion; Coronary Sclerosis. 4201

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 1140 P. to and last saw her/him alive on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at

22a. SIGNATURE (Degree or title) 22b. ADDRESS 22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 3/26/1963 23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery 23d. LOCATION (City, town, or county) St. Ann, Mo.

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE

Collier Mortuary, St. Ann, Mo. MAR 25 1963 Rod Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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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.