

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5312 = 63-021369
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 27 1963

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DATE AMENDED	DOCUMENT
Rev. 4/59			
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68	SHOULD READ	BY AFFIDAVIT OF	
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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 St. Louis,		Length of stay in 1b 64 Years	c. CITY OR TOWN St. Louis, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8612 Halls Ferry Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH BRESNAHAN			4. DATE OF DEATH Month Day Year May 16, 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Ireland
13a. FATHER'S NAME Owen Killoran		13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Cornelius Bresnahan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No None		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Mrs. Julia Denner, 8801 Inkel, Berkeley
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			420.0
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. <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.)	
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 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 10-4-57 to 5-16-63 and last saw her <input checked="" type="checkbox"/> alive on 5-4-63 Death occurred at 10:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Henry W. Keller M.D.		22b. ADDRESS 9440 Midland Overland 21, Mo	22c. DATE SIGNED 5/19/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 18, 1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Bl.		25. DATE RECD, BY LOCAL REG. MAY 17 1963	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Henry Noller
9440 Midland

HOURS: Friday
9:30AM to 12 Noon
1 to 3:30 PM

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 Robert E. Mahleman

Licensed Embalmer No. 4966
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.