

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026124

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6093 STATE FILE NUMBER

**FILED JUN 21 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <p style="text-align: center; font-size: 1.2em;"><b>St. Louis</b></p> b. CITY (if outside corporate limits, give TOWNSHIP only) <p style="text-align: center; font-size: 1.2em;"><b>St. Louis</b></p> Length of stay in 1b c. CITY OR TOWN <p style="text-align: center; font-size: 1.2em;"><b>St. Louis</b></p> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <p style="text-align: center; font-size: 1.2em;"><b>Missouri</b></p> COUNTY b. CITY OR TOWN <p style="text-align: center; font-size: 1.2em;"><b>St. Louis</b></p> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <p style="text-align: center; font-size: 1.2em;"><b>St. Anthony Hosp</b></p> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <p style="text-align: center; font-size: 1.2em;"><b>5236 Grace</b></p> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) <p style="text-align: center; font-size: 1.2em;"><b>THOMAS A Mc ALONE SR</b></p> First Middle Last			<b>4. DATE OF DEATH</b> <p style="text-align: center; font-size: 1.2em;"><b>6-7-1963</b></p> Month Day Year				
<b>5. SEX</b> <p style="text-align: center; font-size: 1.2em;"><b>Male</b></p>	<b>6. COLOR OR RACE</b> <p style="text-align: center; font-size: 1.2em;"><b>White</b></p>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <p style="text-align: center; font-size: 1.2em;"><b>3-31-1894</b></p>	<b>9. AGE (last birthday)</b> <p style="text-align: center; font-size: 1.2em;"><b>69</b></p>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during 1 year preceding death) <p style="text-align: center; font-size: 1.2em;"><b>Letter Carrier</b></p>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <p style="text-align: center; font-size: 1.2em;"><b>U.S.A.</b></p>		<b>11. BIRTHPLACE</b> (City and state or country) <p style="text-align: center; font-size: 1.2em;"><b>Moberly MO.</b></p>		<b>12. CITIZEN OF WHAT COUNTRY</b> <p style="text-align: center; font-size: 1.2em;"><b>USA</b></p>	
<b>13a. FATHER'S NAME</b> <p style="text-align: center; font-size: 1.2em;"><b>Thomas A Mc Alone</b></p>			<b>13b. MOTHER'S MAIDEN NAME</b> <p style="text-align: center; font-size: 1.2em;"><b>Ella Boyle</b></p>			<b>14. NAME OF HUSBAND OR WIFE</b> <p style="text-align: center; font-size: 1.2em;"><b>Corinne Lohman Mc Alone</b></p>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give year and dates of service) <p style="text-align: center; font-size: 1.2em;"><b>Yes W.W.I</b></p>			<b>16. SOCIAL SECURITY NO.</b> [Redacted]		<b>17. INFORMANT</b> Address <p style="text-align: center; font-size: 1.2em;"><b>Corinne Mc Alone 5236 Grace</b></p>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour s.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		

21. I attended the deceased from 9 P M to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <p style="text-align: center; font-size: 1.2em;"><i>Helen L. Taylor, Coroner</i></p>		<b>22b. ADDRESS</b> <p style="text-align: center; font-size: 1.2em;"><i>1300 Clark Ave.</i></p>		<b>22c. DATE SIGNED</b> <p style="text-align: center; font-size: 1.2em;"><i>6-10-63</i></p>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <p style="text-align: center; font-size: 1.2em;"><b>Burial</b></p>		<b>23b. DATE</b> <p style="text-align: center; font-size: 1.2em;"><b>6-11-1963</b></p>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p style="text-align: center; font-size: 1.2em;"><b>S.S. Peter &amp; Paul Cem.</b></p>	
<b>23d. LOCATION</b> (City, town, or county) (State) <p style="text-align: center; font-size: 1.2em;"><b>St. Louis, Mo.</b></p>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <p style="text-align: center; font-size: 1.2em;"><b>Wingermuehle 3819 So Grand Blvd</b></p>		<b>25. DATE RECD. BY LOCAL REG.</b> <p style="text-align: center; font-size: 1.2em;"><b>JUN 10 1963</b></p>	
<b>26. REGISTRAR'S SIGNATURE</b> <p style="text-align: center; font-size: 1.2em;"><i>Paul Smith, M.D.</i></p>					

DO NOT WRITE ON THIS STUB  
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 VS 300 Rev. 4/59  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 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

*George J. Kingbermuck*

Licensed Embalmer No.

4611

P. O. Address

*Adonir 8 No*

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.