

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026245

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6643**

STATE FILE NUMBER

**FILED JUN 28 1963**

VS 300  
Rev. 4/59

1  
2 **222**

3  
4 **0**  
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12 **90-0**  
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**90**

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. 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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>1029 S. 12<sup>th</sup> ST</b>		d. STREET ADDRESS (If outside, give location) <b>1029 S. 12<sup>th</sup> ST</b>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR J O'HANLON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MAINTENANCE MAN SHELL BLDG</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POTOSI MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>
13a. FATHER'S NAME <b>JAMES P O'HANLON</b>		13b. MOTHER'S MAIDEN NAME <b>MARY FLYNN</b>	14. NAME OF HUSBAND OR WIFE <b>MATHILDA O'HANLON</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		17. INFORMANT Address <b>MATHILDA FISHER 1029 S. 12<sup>th</sup> ST</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute left ventricular failure</b> <b>coronary arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Arteriosclerotic Heart Disease</b> <b>coronary atherosclerosis</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 hr</b>
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
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.) <b>4201</b>	
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		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 <b>Sept. 1962</b> to <b>6-24-63</b> and last saw her alive on <b>6-23-63</b> Death occurred at <b>6-24-63 6:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W. B. Weisbrod M.D.</b> (Degree or title)		22b. ADDRESS <b>1410 S. 12<sup>th</sup> ST</b>	
22c. DATE SIGNED <b>6-25-63</b>		22d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JUNE 27, 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS MO.</b>	
24. FUNERAL DIRECTOR <b>Thomas Katis 2906 Gravois</b>		25. TIME REC'D BY LOCAL REG. <b>JUN 25 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

EM-1050-870

1100

1001

870

Dr. Meacham  
11/10/80 of R. H. Co.  
of Ga. 1-1055

1-5 Ave.  
1003-5858

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 J. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Graves

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.

SUB 1-1050