

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033500

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8078** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 22 1963

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		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
		<b>St. Louis</b>				<b>Missouri</b>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>City Hospital</b>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>1523 1/2 Destrahan St.</b>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH Month Day Year			
<b>JOSEPH A. CALLANAN</b>						<b>AUG. 6 1963</b>			
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		
<b>Male</b>	<b>White</b>		<b>6-5-1894</b>	<b>69</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
<b>Retired Machinist</b>		<b>City Art Museum</b>		<b>St. Louis, Missouri</b>		<b>U.S.A.</b>			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
<b>Michael Callanan</b>			<b>Mary Witte</b>			<b>Martha Callanan (Dec'd)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of *****)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
<b>No</b>			<b>53</b>		<b>Robert Callanan, 5747 Park Lane</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)									
<b>Chronic Endocarditis;</b>									
<b>Pulmonary Edema</b>									
DUE TO (b)									
<b>421.4</b>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)								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 checked="" type="checkbox"/> NO <input 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 s.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 <b>7:00 p.m.</b> 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.									
22a. SIGNATURE (Degree or title)			22b. ADDRESS			22c. DATE SIGNED (State)			
<b>Paul J. Simon</b> <i>Coroner</i>			<b>1300 Clark</b>			<b>8/8/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)			
<b>Burial</b>		<b>8/10/63</b>		<b>Calvary Cemetery</b>		<b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
<b>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</b>			<b>AUG 8 1963</b>		<b>Paul Smith, M.D.</b>				

USE BLACK INK OR TYPEWRITER RIBBON

CONFIDENTIAL

2008

2008

2008

**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.M. Rister*

Licensed Embalmer No. 3980

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.