

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038401

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2756

VS 300
Rev. 4/59

1 4036

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USE BLACK INK OR TYPEWRITER RIBBON

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 ST LOUIS,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN PINE LAWN		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 SHRAMOCK NURSING HOME 3709 MANOLA		d. STREET ADDRESS (If outside, give location) 4019 NORTH MARKET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last JAMES J. (MULLANY) MULLANEY			4. DATE OF DEATH Month Day Year SEPT 2, 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG 15, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) IRELAND
13a. FATHER'S NAME JAMES MULLANEY		13b. MOTHER'S MAIDEN NAME KATHERINE HIGGINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I		17. INFORMANT Address AGNES HANLEY 4019 NORTH MARKET ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4221			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (Given in PART I (a)) <i>Chronic brain Syndrome, Nephronephritis</i>			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.)	
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 <i>April 10, 1962</i> to <i>Sept 2, 1963</i> and last saw him alive on <i>Aug 30, 1963</i> Death occurred at <i>2:30 AM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Leaves Luttman MD</i>		22b. ADDRESS <i>8231 Clayton Rd (17)</i>	22c. DATE SIGNED <i>9/4/63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/5/63	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) ST LOUIS MISSOURI
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. 9-4-63	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>

Dr. Littmann
8231 Clayton
Pal 7-0600
mes 1 till 5
wed r till 5

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

M W Rueter

Licensed Embalmer No.

4865

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.