

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042432

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 3243 STATE FILE NUMBER

FILED OCT 30 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Ferguson St Louis</u>		a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) Length of stay in 1b <u>Ferguson</u> <u>3 wks</u>		c. CITY OR TOWN <u>Jennings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Oak Knoll Home</u>		d. STREET ADDRESS (If outside, give location) <u>7592 Park Town North</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED First Middle Last <u>IRENE SLATTERY</u>			4. DATE OF DEATH Month Day Year <u>Oct 22 1963</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1890</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>George Wigglesworth</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Meredith</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Susan Rosenstein 7592 Park Town N</u>		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), and (d).) PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
IMMEDIATE CAUSE (a) <u>CARCINOMA OF LEFT OVARY with metastasis</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS.</u>						
DUE TO (c) <u>CHRONIC BRAIN SYNDROME.</u>						
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.	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 <u>Sept. 28, 1963</u> to <u>Oct 22, 1963</u> and last saw her alive on <u>Oct. 15, 1963</u> Death occurred at <u>3:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Charles Kilo, M.D.</u>			22b. ADDRESS <u>135 West Adams, Kirkwood 22, Missouri</u>		22c. DATE SIGNED <u>Oct. 22, 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/24/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Co Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-22-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address _____

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.