

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049828

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12475** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300	AMENDED
Rev. 4/59	
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2 <b>2059</b>	
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4 <b>1</b>	
5 <b>2</b>	
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12 <b>75-0</b>	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

SHOULD READ

DATE AMENDED

ITEM NO.

75

FILED DEC 27 1963

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		Length of stay in 1b <b>2 HRS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>				c. CITY OR TOWN <b>St. Louis</b>		d. STREET ADDRESS (If outside, give location) <b>6219 Westminister</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6219 Westminister</b>							
3. NAME OF DECEASED (Type or print) <b>GRACE</b>			First Middle Last <b>O'MARA</b>			4. DATE OF DEATH Month Day Year <b>Dec. 15th 1963</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</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>7-21-1890</b>		9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days <b>4 24</b>		IF UNDER 24 HR Hours Min. <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Board of Education</b>				11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Harry McCaffery</b>				13b. MOTHER'S MAIDEN NAME <b>Alicia Hymes</b>				14. NAME OF HUSBAND OR WIFE <b>William O'Mara</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dr. J.J. McCaffery 6219 Westminister</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 Intestinal Obstruction</b>										INTERVAL BETWEEN ONSET AND DEATH <b>32 hrs.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										<b>570.5</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Mild Senile Dementia</b>								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. 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>1960</b> to <b>12/15/63</b> and last saw her <sup>her</sup> <del>last</del> alive on <b>12/15/63</b> Death occurred at <b>7 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>D.W. McShane M.D.</b>						22b. ADDRESS <b>4500 Olive St. St. Louis Mo</b>			22c. DATE SIGNED <b>12/17/63</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 18, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>						
24. FUNERAL DIRECTOR <b>A. H. BOCKLAGE</b>				ADDRESS <b>6536 Clayton Rd.</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 17 1963</b>		26. REGISTRAR'S SIGNATURE <b>Coal Smith M.D.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.