

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-046492

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3883

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 23 1965

VS 300  
Rev. 4/59

1 4000

2 4000

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4 1

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7 0

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9 581.0

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11

12 90.0

13

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<br>a. COUNTY <b>St. Louis</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Lemay</b>   |   | c. CITY OR TOWN <b>Lemay</b>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1534 Telegraph Road</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>1534 Telegraph Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>May</b> Middle <b>Jean</b> Last <b>O'Bannon</b>   |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>13</b> Year <b>1965</b>  |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH <b>11-2;-1907</b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                     |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Salem, Mo.</b> |
| 13a. FATHER'S NAME<br><b>John Sweeney</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Bedwell</b>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Sam M.</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>489-03-8335</b>   |   | 17. INFORMANT<br><b>Sam M. O'Bannon</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic coma</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b>  |   |
| DUE TO (b) <b>Portal cirrhosis of liver</b>   |   | <b>6 mons.</b>  |   |
| DUE TO (c)  |   |   |   |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>12-11-59</b> to <b>11-13-65</b> and last saw her/him alive on <b>11-12-65</b>                                   |   | Death occurred at <b>12 noon</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |
| 22a. SIGNATURE <i>John J. Rath</i> (Degree or title)  |   | 22b. ADDRESS <b>M.D. 634 N. Grand Blvd.</b>   |   |
| 22c. DATE SIGNED <b>11-15-65</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>11-16-1965</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>  |   |
| 23d. LOCATION (City, town, or county) (State)<br><b>1215 Lemay Ferry Rd. Lemay, Mo.</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Hoffmeister Mortuaries Inc.</b><br>7814 S. Broadway  |   | 25. DATE RECD. BY LOCAL REG. <b>NOV 15 1965</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><i>John C. Murphy M.D.</i>   |   |   |   |

USE BLACK INK OR TYPEWRITER RIBBON

001236-618

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 *Lee C. Hanson*

Licensed Embalmer No. 4764

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.

Bo. of Health  
# 823  
St. Louis Mo  
JE 3-7469