

Registration District No.

~~500~~

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DE PAUL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
(Specify whether
In this community 12 Day
years, months or days)

3. (a) PRINT FULL NAME VIOLA JANE MONTGOMERY

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JAMES TIGAN 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased JUNE 13 1892
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 23 If less than one day hr. min.

9. Birthplace GREENE CO. ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business HOUSEWIFE

12. Name SAMUEL DUNNINGHAM

13. Birthplace GREENE Co. ILL.
(City, town, or county) (State or foreign country)

14. Maiden name ALICE GOODALL

15. Birthplace GREENE Co. ILL.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Fred Shaw

(b) Address 907 main st. Alton Ill.

17. (a) BURIAL (b) Date thereof Nov. 9 1949
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation wrights See

18. (a) Signature of funeral director S. B. Benson, Director

(b) Address 603 Henry St. Alton Ill.

19. (a) NOV 8 1949 (b) J. B. Lassiter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County GREENE
(c) City or town GREENFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 406 Sycamore
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country N.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 6
year 1949 hour 1:00 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 10 to Nov 6, 1949
that I last saw her alive on Nov 6, 1949
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Rheumatoid mitral + aortic endocarditis

Due to Glomerulonephritis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature N. H. Muttachuk (M. D. or other)

Address 3903 Olive St. Date signed 11/7/49

MOTHER FATHER

Duration

1 wk

5 yrs

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Barbara Linnis*

Licensed Embalmer No. *5796*

P. O. Address *603 Henry Altos*

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 this body is not embalmed, fact should be so stated above.