

FILED JUN 29 1951

STANDARD CERTIFICATE OF DEATH

21403

State File No. \_\_\_\_\_ Registrar's No. 5531

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Granite City 8120	
c. LENGTH OF STAY (in this place) 7 days		d. STREET ADDRESS (If rural, give location) 2600 Missouri 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) Laura			a. (First)		b. (Middle)		c. (Last) Proctor		4. DATE OF DEATH (Month) (Day) (Year) 6 17 51				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 1-5-1877		9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Sam Oliver Sr.		13b. MOTHER'S MAIDEN NAME Lucinda B Dowsett Daniels		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beulah Forehand Granite City			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolus						? 1 yr.	
		ANTECEDENT CAUSES							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) Carcinoma of stomach with localized peritonitis							
		DUE TO (c) Generalized arteriosclerosis						? 10 yrs.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		151X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from 6-12-1951, to 6-17-1951, that I last saw the deceased alive on 6-17, 1951, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE FR Bradley		(Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 6/17/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-17-51		24c. NAME OF CEMETERY OR CREMATORY madison		24d. LOCATION (City, town, or county) (State) Ill	

DATE REC'D BY LOCAL REG. JUN 19 1951		REGISTRAR'S SIGNATURE Dr B Carter		25. FUNERAL DIRECTOR'S SIGNATURE Francis G. Shoy		ADDRESS madison Ill	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1899

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Peter Dubrouillet*

Signed.....

Student Embalmer

Licensed Embalmer No. 3691

P. O. Address St Louis 1

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.