

THE DIVISION OF HEALTH OF ILLINOIS
STANDARD CERTIFICATE OF DEATH

State File No.

8112

S. No. 300

EV. 10.48

ED SEP 8 1952

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Illinois b. COUNTY 8120	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d		c. LENGTH OF STAY (in this place) 6 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		e. STREET ADDRESS (If rural, give location) Rural Route	

3. NAME OF DECEASED (Type or Print) a. (First) NANCY b. (Middle) PFEFFER c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 8-27-52					
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married	8. DATE OF BIRTH 7-26-1930	9. AGE (In years last birthday) 22	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 MIN. Hours	# UNDER 1 MIN. 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 (City and State or Foreign Country) Lincoln, Ill. /		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Dean Harris		13b. MOTHER'S MAIDEN NAME Dorothy Russell		14. NAME OF HUSBAND OR WIFE John Pfeffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Pfeffer, Lebanon, Ill.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Respiratory paralysis</i> ANTECEDENT CAUSES <i>Poliomyelitis</i> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Poliomyelitis</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION 8-22-52		19b. MAJOR FINDINGS OF OPERATION tracheotomy		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 0803	

22. I hereby certify that I attended the deceased from 8-21, 1952, to 8-27, 1952, that I last saw the deceased alive on 8-27, 1952, and that death occurred at 1:29 p.m., from the causes and on the date stated above.

23a. SIGNATURE Joseph E. Carney M.D. (Degree or title)		23b. ADDRESS 906 Olive St		23c. DATE SIGNED 8-27-52	
24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE 8-27-52		24c. NAME OF CEMETERY OR CREMATORY	
				24d. LOCATION (City, town, or county) (State) Lebanon, Ill.	

DATE REC'D BY LOCAL REG. AUG 27 1952		REGISTRAR'S SIGNATURE J. Carney M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Meyer F. H., Lebanon, Ill.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Ben Hoffman

Licensed Embalmer No. 4366

P. O. Address St Louis 10

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.