

THE DIVISION OF HEALTH OF THE STATE OF ILLINOIS  
STANDARD CERTIFICATE OF DEATH

State File No. **12950**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 28 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **2054** Registrar's No. **45**

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Louisiana</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (Rural) <b>Pleasant Hill Twp</b>	
c. LENGTH OF STAY (in this place) <b>60 days</b>		d. STREET ADDRESS (If rural, give location) <b>None</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pike County Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Zula</b>	b. (Middle) <b>Mae</b>	c. (Last) <b>Shaw</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 22, 1954</b>
-------------------------------------	------------------------	------------------------	-----------------------	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 2, 1916</b>	9. AGE (In years last birthday) <b>37</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
----------------------	-------------------------------	---	--------------------------------------	---	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Hamilton, Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	---	--	---

13a. FATHER'S NAME <b>Roy Srite</b>	13b. MOTHER'S MAIDEN NAME <b>Edith Fancher</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph R. Shaw</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. <b>303-01-1436</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Joseph R. Shaw</b>	ADDRESS <b>Pleasant Hill, Ill</b>
--	--	---	-----------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Renovascular disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Due to (b) Coronary thrombosis</b> <b>Due to (c) c mitosis</b>		
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	---	----------------------------

22. I hereby certify that I attended the deceased from **2-21, 1954** to **4-22, 1954** that I last saw the deceased alive on **4-21, 1954**, and that death occurred at **12:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Chas. H. Luedler M.D.</b> (Degree or title)	23b. ADDRESS <b>Louisiana Mo</b>	23c. DATE SIGNED <b>4/22/54</b>
---	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-23-54</b>	24c. NAME OF CEMETERY OR OTHER PLACE <b>Little Eagle</b>	24d. LOCATION (City, town, or county) (State) <b>Hamilton Co. Indiana</b>
--	--------------------------	--	---

DATE RECD BY LOCAL REG. <b>April 22, 1954</b>	REGISTRAR'S SIGNATURE <b>Bernice Collier</b>	1374	25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter M. Platt</b>	ADDRESS <b>Pittsfield, Ill</b>
---	--	------	---	--------------------------------

AUG 29 1955

**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.....

*Walter M. Platten*

Signed.....

Student Embalmer

Licensed Embalmer No. *5710-2ll*

P. O. Address *Pittsfield 2ll*

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.