

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6636

1555

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

1. PLACE OF DEATH
a. COUNTY2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Illinois b. COUNTYb. CITY (If outside corporate limits, write RURAL and give town or township)
TOWN St. Louis, Mo.

c. LENGTH OF STAY (in this place)

c. CITY OR TOWN Carmi

d. Is Residence within limits of a city or incorporated town?
Yes No d. FULL NAME OF HOSPITAL OR INSTITUTION
BARNES HOSPITAL O

STREET ADDRESS RR#5 (If rural, give location)

81208

3. NAME OF DECEASED
(Type or Print)

a. (First)

James

b. (Middle)

Ried

c. (Last)

York

4. DATE OF DEATH

(Month) (Day) (Year)

2-16-55

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

1-7-1913

9. AGE (in years last birthday)

42

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

bartender

10b. KIND OF BUSINESS OR INDUSTRY

tavern

11. BIRTHPLACE (City and State or Foreign Country)

Illinois

12. CITIZEN OF WHAT COUNTRY?

USA

13a. FATHER'S NAME

James E. York

13b. MOTHER'S MAIDEN NAME

Sarah Vanway

14. NAME OF HUSBAND OR WIFE

unknown

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.

841-14-6948

17. INFORMANT'S SIGNATURE OR NAME

Hospital Records

ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
8 yrs.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

Congestive Heart Failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Rheumatic Heart Disease

DUE TO (c)

Many yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

2/16/55

19b. MAJOR FINDINGS OF OPERATION

As above

20. AUTOPSY?

YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

4013

22. I hereby certify that I attended the deceased from 1-30, 1955, to 2-16, 1955, that I last saw the deceased alive on 2-16, 1955, and that death occurred at 11:15am., from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

23b. ADDRESS

BARNES HOSPITAL

23c. DATE SIGNED

2-16-55

24a. BURIAL, CREMATION, REMOVAL (Specify)

removal

24b. DATE

2-17-55

24c. NAME OF CEMETERY OR CREMATORY

(State)

Carmi, Illinois

DATE REC'D BY LOCAL REG.

FEB 18 1955

REGISTRAR'S SIGNATURE

Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE

Kittinger, Carmi, Ill.

ADDRESS

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.....
Signature of Student Embalmer

Signed *Dill C. Brance*.....

Licensed Embalmer No. *47*.....

P. O. Address *St. Louis*.....

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.