

No. 300
10-48

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35488
Registrar's No. 2396

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois, b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Berkeley City, MO.		c. CITY OR TOWN Galesburg	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 27 Mos.		e. STREET ADDRESS (If rural, give location) -- Rural 812 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Penn Nursing Home,			
3. NAME OF DECEASED (Type or Print) a. (First) Almira	b. (Middle) Jane	c. (Last) Archer	4. DATE OF DEATH (Month) (Day) (Year) Oct. 18, 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 28, 1868
9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Brown County, Illinois,	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME James Tolle	13b. MOTHER'S MAIDEN NAME Jane DeWitt	14. NAME OF HUSBAND OR WIFE Wm. S. Archer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Nil.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie Graff, 4016 Botanical Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiac-vascular disease		INTERVAL BETWEEN ONSET AND DEATH unknown
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension		unknown
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)	4221
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 13, 1953 to Oct 18, 1955, that I last saw the deceased alive on Oct 16, 1955, and that death occurred at 8:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Lewis Lettmann (Degree or title)	23b. ADDRESS 8231 Clayton Rd	23c. DATE SIGNED 10/18/55	
24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 10-18-55	24c. NAME OF CEMETERY OR CREMATORY Lynnwood Cemetery	24d. LOCATION (City, town, or county) (State) Galesburg, Illinois,
DATE REC'D BY LOCAL REG. 10-18-55	REGISTRAR'S SIGNATURE Herbert R. Dombke MD.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	

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 *J. W. Wilkinson*.....

Licensed Embalmer No. *35*.....

P. O. Address *H. Lou*.....

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.