

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10521

State File No.

3116

XC-15 853 643
Reg. 15728

FILED APR 6 - 1956

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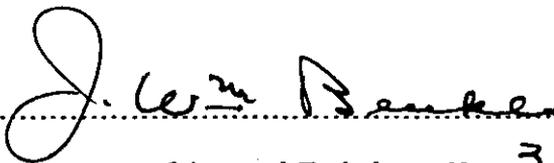
Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY LAWRENCE			
b. CITY (If outside corporate limits, write RURAL and give township) 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (In this place) 11 days		c. CITY OR TOWN LAWRENCEVILLE	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hosp.		e. STREET ADDRESS (If rural, give location) 812⁰ S			
3. NAME OF DECEASED (Type or Print) a. (First) CECIL b. (Middle) DALE c. (Last) CARIE			4. DATE OF DEATH (Month) (Day) (Year) 3-27-56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 11-1-26	9. AGE (In years last birthday) 29 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) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) LAWRENCEVILLE, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME EDMON CARIE		13b. MOTHER'S MAIDEN NAME MYRTLE POTTS	
13c. NAME OF HUSBAND OR WIFE NELDA CARIE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-2		16. SOCIAL SECURITY NO. 322 20 9577	
17. INFORMANT'S SIGNATURE OR NAME VA Hosp. Records, 915 N. Grand, St. Louis, Mo.		17. ADDRESS		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) GENERALIZED PERITONITIS DUE TO PERFORATION OF GASTRIC ULCER		ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Appx 3 days	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> HODGKINS DISEASE, GENERALIZED		Undetermined		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 540.1 H		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"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 3-16-56 , 19__, to 3-27-56 , 19__, which is the date of the deceased's death , and that death occurred at 9:15 a m. , from the causes and on the date stated above.	
23a. SIGNATURE W. Westmaelinger (Degree or title)		23b. ADDRESS 915 N. Grand M.D. VA Hospital, St. Louis, Mo.		23c. DATE SIGNED 3-27-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-27-56		24c. NAME OF CEMETERY OR CREMATORY Local	
24d. LOCATION (City, town, or county) (State) Lawrenceville, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		25. ADDRESS 4700m Washington,	
DATE REC'D BY LOCAL REG. MAR 28 1956		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. ADDRESS 4700m Washington,	

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.....


Licensed Embalmer No.....3

P. O. Address.....


Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.