

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

25439

State File No. _____

FILED JUL 18 1956

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 544 Registrar's No. 1594

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkwood</u>		c. CITY OR TOWN <u>Dixon</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>733 Craig Woods</u>		e. STREET ADDRESS (If rural, give location) <u>322 West Everett Street</u> <u>81208</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>KLEIN</u>	c. (Last) <u>COTTER</u> <input checked="" type="checkbox"/>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 30th, 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 28, 1893</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u>	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Storm Lake, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Amand Klein</u>	13b. MOTHER'S MAIDEN NAME <u>Gertrude Liertz</u>	14. NAME OF HUSBAND <u>John Cotter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Axline</u> ADDRESS <u>733 Craig Woods</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> <u>5 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>General Arteriosclerosis</u>		
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 <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>4201</u>
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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? _____
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22: I hereby certify that I attended the deceased from June 26, 1956, to June 30, 1956, that I last saw the deceased alive on June 30, 1956, and that death occurred at 10 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Martin W. Davis, MD</u> (Degree or title)	23b. ADDRESS <u>539 N. Grand</u>	23c. DATE SIGNED <u>7/1/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>July 1 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Dixon, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>7-1-56</u>	REGISTRAR'S SIGNATURE <u>Herbert P. Donahue</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. R. Lupton & Sons</u> ADDRESS <u>7233 Delmar Blv'd.</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

S. No. 300
V. 10.48

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.. *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.