Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10308

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2003

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Sherman 8/20/8 Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES Length of stay in 1b 8 days	d. STREET ADDRESS 32 R.R.#1 (If outside, give location) Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
LORRAINE	NMN	GOCHANOUR	FEB. 26, 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Female	White		Mar. 17, 1905	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Hawesville, Ky.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		none	George Gochanour, R.R.#1, Sherman, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) AORTIC STENOSIS

DUE TO (c) RHEUMATIC HEART DISEASE — 20 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 416x

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
☐	☐	☐	

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from FEB. 18, 1957 to FEB. 26, 1957 and last saw her him alive on FEB. 26, 1957

Death occurred at 11:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
C. C. Vermillion, M.D.	BARNES HOSPITAL	2/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
removal	2-27-57	Rose Lawn, Cemetary	Springfield, Ill

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Staab Funeral Home, Springfield, Ill.	FEB 27 '57	Earl Smith MD mJB

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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