

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46398
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12641

5. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GRANITE CITY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS <u>2983 WASHINGTON</u>
3. NAME OF DECEASED (Type or print)		First <u>OTTO</u> Middle <u>NMN</u> Last <u>TREECE</u>	4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>26</u> Year <u>1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CELOTEX CO.</u>	9. AGE (In years at 1st birthday) <u>51</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>ST. FRANCISVILLE, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>CLINTON TREECE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ORAND</u>	
14. NAME OF HUSBAND OR WIFE <u>LENA TREECE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES. WW 2</u>	
16. SOCIAL SECURITY NO. <u>333-01-9585</u>		17. INFORMANT Address <u>Balance Vale 2983 Washington</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE TUBULAR NECROSIS</u> DUE TO (b) <u>THROMBO-endarterectomy</u> DUE TO (c) <u>ARTERIOSCLEROSIS OF ABDOMINAL AORTA WITH THROMBOSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>450.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u> <u>10 DAYS</u> <u>10 YEARS</u>
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>DEC. 22, 1957</u> to <u>DEC. 26, 1957</u> and last saw her/him alive on <u>DEC. 26, 1957</u> -Death occurred at <u>9:35 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Harvey Berrod</u> (Degree or title) <u>Harvey Berrod</u>		22b. ADDRESS <u>BARNES HOSPITAL</u> <u>M. D.</u>	
22c. DATE SIGNED <u>12/27/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>12-27-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>	
23d. LOCATION (City, town, or county) <u>GRANITE CITY, ILLINOIS</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Frank Meccer</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 31 57</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		27. (Initials) <u>m 83</u>	

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 *Charles E. Meeker*

Licensed Embalmer No. *2988*
P. O. Address *Quincy, Ill.*

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.