

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002993  
STATE FILE NUMBER  
2 678  
Registrar's No.

FILED FEB 4 1959

Registration District No. Primary Registration District No.

5. 300

1-57

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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>JACKSONVILLE</u> 4120 d. STREET ADDRESS <u>300 1/2 E. LAFAYETTE</u>
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>W.</u> Last <u>GREEN</u>		4. DATE OF DEATH <u>JANUARY 20, 1959</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>— 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPUTY SHERIFF</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>JACKSONVILLE Ill.</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>SARAH GREEN</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>SARAH GREEN 300 1/2 E. LAFAYETTE</u> Address <u>JACKSONVILLE Ill.</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 MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>EXPLORATORY THORACOTOMY</u>			<u>6 DAYS</u>
DUE TO (c) <u>BRONCHOGENIC CARCINOMA OF LEFT LUNG 162.1</u>			<u>1 1/2 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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>JAN. 8, 1959</u> , to <u>JAN. 20, 1959</u> and last saw <sup>her</sup> him alive on <u>JAN. 20, 1959</u> Death occurred at <u>9:12 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title) M. D.		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/20/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JAN. 20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>JACKSONVILLE CITY CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>JACKSONVILLE ILLINOIS</u>
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JAN 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Charles Smith, M.D.</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 *Clarence H. Murray* .....

Licensed Embalmer No. *408* .....  
P. O. Address *St. Louis, Mo.* .....

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.