

59-010676

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED MAR 27 1959

 Registration District No. _____ Primary Registration District No. _____ Register No. **2680**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY LOGAN					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Lincoln		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Length of stay in 1b		d. STREET ADDRESS 518 N. Hamilton		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Elizabeth Middle K. Last Aughton				4. DATE OF DEATH Month 3 Day 15 Year 1959					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1924		9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months 3 Days 11	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher - Pottery			10b. KIND OF BUSINESS OR INDUSTRY Company		11. BIRTHPLACE (City and state or country) HARTSBURG ILL. 1		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME HENRY B KLOCKENGE			13b. MOTHER'S MAIDEN NAME KATE WESTON			14. NAME OF HUSBAND OR WIFE MR. DANIEL AUGHTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NONE		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lincoln Ill. MR. DANIEL AUGHTON 518 N. Hamilton					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 41 hrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Leukemia and Thrombocytopenia							6 mos.		
DUE TO (c) 204.4									
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 checked="" type="checkbox"/> NO <input 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 March 7, 1959 , to March 15, 1959 and last saw her alive on March 15, 1959 Death occurred at 5:05 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE F R Bradley M. D.			22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 3-15-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 3/16/59	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Lincoln Illinois				
24. FUNERAL DIRECTOR Lincoln Illinois. Holland and Barry Funeral Home				25. DATE RECD. BY LOCAL REG. MAR 16 59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
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

(Augustine
City Line)

View and report to
Holland & Berg F. W.
Funerals, Okemore.

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.

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.