

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011549  
STATE FILE NUMBER

FILED MAR 20 1959  
68936570

SL 18955

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2428**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MARION</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND, ST LOUIS MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CENTRALIA</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET ADM. HOSPITAL</b>		Length of stay in lb <b>36 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>1209 S MAPLE STREET</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>NORMAN</b>	First	Middle	Last	4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>1959</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/25/13</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) <b>CENTRALIA, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>FRED YATES</b>	13b. MOTHER'S MAIDEN NAME <b>SOPHIA KUHLMAN</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES</b>	16. SOCIAL SECURITY NO. <b>345-03-2050</b>	17. INFORMANT <b>VA HOSP. RECORDS, ST. LOUIS, MISSOURI</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMBRYONAL CARCINOMA, ADENOMATOUS, OF THE RIGHT TESTICLE.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>METASTASIS TO LIVER</b>	UNKNOWN
	DUE TO (c) <b>METASTASIS TO LUNGS</b> <b>178X</b>	UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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
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21. I attended the deceased from <b>1-29-59</b> to <b>3-6-59</b> and last saw <sup>him</sup> <del>him</del> alive on <b>3-6-59</b> Death occurred at <b>10:10 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>J. L. OSTERHOFF M.D.</b>	22b. ADDRESS <b>VAH, 915 N GRAND, ST LOUIS, MO.</b>	22c. DATE SIGNED <b>3/7/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-7-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Centralia, Ill.</b>
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24. FUNERAL DIRECTOR <b>Queen-Boggs, Centralia, Ill.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>MAR 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

**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 M. Billo* .....

Licensed Embalmer No. *4375* .....  
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.