

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025012

FILED VS AUG 10 1959

3523

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3523

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> COUNTY <b>Sangamon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>2 days</b>	c. CITY OR TOWN <b>Springfield</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4541 Main St. Apt.25</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>853 South Douglas St.</b>

3. NAME OF DECEASED (Type or print) First <b>GORDON</b> Middle <b>RUSSELL</b> Last <b>BROOKS</b>	4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>59</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-01</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Manager</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Holland Furnace Co.</b>	11. BIRTHPLACE (City and state or country) <b>Worcester Mass.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles Brooks</b>	13b. MOTHER'S MAIDEN NAME <b>Evangeline Jones</b>	14. NAME OF HUSBAND OR WIFE <b>Mora L. Brooks</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>565-16-9990</b>	17. INFORMANT Address <b>Mora L. Brooks; 853 So. Douglas St. Springfield, Ill</b>
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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>Coronary Occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Long history smoking</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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. _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Michael H. Owens County</b>	22b. ADDRESS <b>1034 Pratt Blvd</b>	22c. DATE SIGNED <b>7-20-59</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-21-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Live Oak Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Monrovia Calif.</b>
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24. FUNERAL DIRECTOR <b>WEILERT FUNERAL HOMES(S) K.C., MO.</b>	25. DATE RECD. BY LOCAL REG. <b>7-20-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF MICHAEL H. OWENS

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer, No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*B. E. Weiler*

Licensed Embalmer No. 4075

P. O. Address. K. C. S. M.

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.