

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027374

8 FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 6648** STATE FILE NUMBER

|  |  |   |   |
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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>              |  | Length of stay in lb<br><b>7 DAYS</b>   | c. CITY OR TOWN <b>GRANITE CITY</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>JEWISH HOSPITAL</b> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                | d. STREET ADDRESS (If outside, give location) <b>2757 SUNSET DRIVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>DONALD</b> Middle <b>FREEMAN</b> Last <b>WOLFE</b> | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>14</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>10-4-55</b> | 9. AGE (last birthday) <b>3</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|--------------------|-------------------------------|--|---------------------------------|---------------------------------|--|--|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <b>GRANITE CITY, ILL.</b> | 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b> |
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|--|---|-----------------------------|
| 13a. FATHER'S NAME <b>WILLIAM M. WOLFE</b> | 13b. MOTHER'S MAIDEN NAME <b>OPAL JANE SCHUCK</b> | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

|   |                                     |   |
|---|-------------------------------------|---|
| 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>NONE</b> | 17. INFORMANT <b>William Wolfe</b> Address <b>5757 Sunset</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, acute, bil</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>atelectasis, bilateral</b> | <b>5 days</b>                                  |
|   | DUE TO (c) <b>Cardiac arrest</b>         | <b>7 days</b>                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Cortical necrosis</b> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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|   |                  |
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| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. | Month, Day, Year |
|---|------------------|

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| 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 **July 8<sup>th</sup> 1959** to **July 14, 1959** and last saw him alive on **July 14<sup>th</sup>**  
Death occurred at **12:30 PM DST** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <b>Benjamin Berman MD</b> (Degree or title) | 22b. ADDRESS <b>1322 W. Madison St., J.C.</b> | 22c. DATE SIGNED <b>7-15-59</b> |
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|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b> | 23b. DATE <b>7-14-1959</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET HILL</b> | 23d. LOCATION (City, town, or county) (State) <b>EDWARDSVILLE, ILLINOIS</b> |
|--|----------------------------|---|---|

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| 24. FUNERAL DIRECTOR <b>Frank Mercer Granite City, Ill</b> ADDRESS | 25. DATE RECD. BY LOCAL REG. <b>JUL 16 '59</b> | 26. REGISTRAR'S SIGNATURE <b>Harold Smith M.D.</b> |
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 Charles E. Mercer

Licensed Embalmer No. 2988

P. O. Address Granite Co.

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.