

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030207

FILED VS SEP 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7676** STATE FILE NUMBER

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>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Xenia</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Route 3</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Maxine</b> Last <b>Allison</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Female</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>11/17/1921</b>
9. AGE (last birthday) <b>37</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Johnsonville, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Norman C. Stull</b>	
13b. MOTHER'S MAIDEN NAME <b>Bessie M. Long</b>		14. NAME OF HUSBAND OR WIFE <b>William Allison</b>	
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 Address <b>William C. Allison, Xenia, Ill.</b>
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>Adrenal Exhaustion ( Shock)</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>Ileal Fistula</b>			<b>14 days</b>
DUE TO (c) <b>Carcinoma of the Cecum</b>			<b>1 1/2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m.	Month _____ Day _____ Year _____		
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 <b>8/19/58</b> to <b>8/15/59</b> and last saw her <sup>her</sup> <del>live</del> <sup>alive</sup> on <b>8/15/59</b>		Death occurred at <b>10:30A.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>7430 Virginia Avenue</b>	22c. DATE SIGNED <b>8/17/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-18-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jacob Chapel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Orchard Twp., Ill.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 10 59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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 \_\_\_\_\_  
*W. K. ...*

Licensed Embalmer No. 6108

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.