

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS OCT 19 1959**

**59-037369**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 9203**

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		a. STATE <b>Illinois</b> b. COUNTY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		c. CITY OR TOWN <b>Belleville</b>	
Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>223 S. Charles St.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<b>EVELYN</b>			<b>AGNE</b>	<b>Oct. 4, 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>5-21-1901</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR	IF UNDER 24 HR
					Months	Days
					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>Home</b>	11. BIRTHPLACE (City and state or country) <b>Belleville, Ill</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles Nesbit</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Brenfleck</b>	14. NAME OF HUSBAND OR WIFE <b>August Agne</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>None</b>	17. INFORMANT <b>August Agne, Belleville, Ill.</b>	Address <b>223 S. Charles, St.</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>Intracerebral Hemorrhage &amp; (part of)</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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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)	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
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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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20c. TIME OF INJURY 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
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21. I attended the deceased from <b>9-25-59</b> to <b>10-3-59</b> and last saw her <b>alive</b> on <b>10-3-59</b> Death occurred at <b>7:00</b> <b>4 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>E. A. Imovic M.D.</b>	22b. ADDRESS <b>100 No. Euclid, St. Louis 8, Mo.</b>	22c. DATE SIGNED <b>10-6-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-5-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill Cemot.</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville, Ill.</b>
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24. FUNERAL DIRECTOR <b>Gaerdner, Belleville, Ill.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 7 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m d b*

**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

*James M. Billo*

Licensed Embalmer No. 4375

P.O. Address St. Louis, 23, 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.