

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1959

2 9635

59-037509

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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) OR TOWN St. Louis		Length of stay in 1b 11 days	c. CITY OR TOWN Carlinville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 304 So. Locust	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First Middle Last William Andrew Costello			4. DATE OF DEATH Month Day Year October 19, 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/27/1894	9. AGE (last birthday) 65	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) retired telephone Employee		10b. KIND OF BUSINESS OR INDUSTRY Western Electric Co.	11. BIRTHPLACE (City and state or country) Western Mound Twp., Ill.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Edward S. Costello		13b. MOTHER'S MAIDEN NAME Mary Quinn		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 350-09-2327		17. INFORMANT Address Mamie Costello, 304 So. Locust	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 10 hours 3 mos
IMMEDIATE CAUSE (a) Gastric dilatation			
DUE TO (b) Carcinoma of rectum			
DUE TO (c) 1st x			
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 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 Carlinville, Ill.		COUNTY STATE
21. I attended the deceased from 10/18/59 to 10/19/59 and last saw her/him alive on 10/18/59 Death occurred at 3:15 am on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) George B. Rader		22b. ADDRESS 457 N. Kingshighway		22c. DATE SIGNED 10/19/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-21-59	23c. NAME OF CEMETERY OR CREMATORY St. Catherines' Cemetery	23d. LOCATION (City, town, or county) (State) Hagaman, Ill.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. OCT 21 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D. m. g. b.	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH
DIVISION OF ANATOMY

THIS IS TO CERTIFY THAT THE BODY OF _____
DECEASED _____
ON _____
AT _____
CITY OF _____
COUNTY OF _____
STATE OF MISSOURI
WAS EMBALMED BY _____
A LICENSED EMBALMER
NO. _____
ON _____
AT _____
CITY OF _____
COUNTY OF _____
STATE OF MISSOURI

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 Robert M. Mur

Licensed Embalmer No. 3749

P. O. Address St Louis

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.