

DURIE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039549

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 4187 Registrar's No. 259

UNRECORDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY FRANKLIN		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN UNION		c. CITY OR TOWN UNION		d. STREET ADDRESS (If outside, give location) 111 WASHINGTON AVE.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN UNION		Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AT HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 111 WASHINGTON AVE.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First ELLA		Middle MAE		Last ANGELL		Month NOV. Day 23 Year 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1909	
9. AGE (last birthday) 52		IF UNDER 1 YEAR 3 Months 23 Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY SHOE WORKER		11. BIRTHPLACE (City and state or country) GRAF TON, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM COPE			13b. MOTHER'S MAIDEN NAME NORA GREEN			14. NAME OF HUSBAND OR WIFE LESLIE ANGELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 350-12 -3230		17. INFORMANT LESLIE ANGELL 111 WASHINGTON AVE.		
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	
IMMEDIATE CAUSE (a) Acute heart failure						8 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic heart failure						1 year	
DUE TO (c) Rheumatic heart disease						20 years	
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 Month, Day, Year					
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	
21. I attended the deceased from <u>June 1959</u> to <u>November 23, 1959</u> and last saw <u>her</u> alive on <u>November 4, 1959</u> . Death occurred at <u>6:10</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George C. Richardson, M.D.</u>				22b. ADDRESS <u>Medical Arts Clinic, Union, Mo</u>		22c. DATE SIGNED <u>Nov 23, 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE NOV. 25, 1959		23c. NAME OF CEMETERY OR CREMATORY OAK WOOD CEMETERY		23d. LOCATION (City, town, or county) ALTON, ILLINOIS	
24. FUNERAL DIRECTOR OLTMANN FUNERAL HOME UNION, MO.				25. DATE RECD. BY LOCAL REG. <u>11/23/59</u>		26. REGISTRAR'S SIGNATURE <u>F.P. Richardson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 10 1959

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 Ralph Altman
Licensed Embalmer No. 4808

P. O. Address Union, N.J.

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.