

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002245

STATE FILE NUMBER

FILED VS. JAN 22 1960

Registration District No. 162 Primary Registration District No. 5595 Registrar's No. 2

INDEXED

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kimmswick		Length of stay in 1b 6 mo	c. CITY OR TOWN E. St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Four Oakes Nurs Home		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 476 N 23rd St. Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OILLIE Middle M Last WILL			4. DATE OF DEATH Month Jan 14 Day 1960 Year	
--	--	--	---	--

5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/6/65	9. AGE (last birthday) 94	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) HW	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ava, Ills.	12. CITIZEN OF WHAT COUNTRY US
---	-----------------------------------	--	---------------------------------------

13a. FATHER'S NAME James Kerson	13b. MOTHER'S MAIDEN NAME Julia Ledbetter	14. NAME OF HUSBAND OR WIFE Irvin Will (Dec)
--	--	---

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. no	17. INFORMANT Address Dr L A Will, 4500 Olive, St. Louis Mo
--	-----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease DUE TO (b) Generalized arterio-sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

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 2 Month, Day, Year PAN a.m. p.m.	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 Aug. 1959 to date and last saw her live on 12/26/59 . Death occurred at 2 PAN m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Deedee or title) Frank Huck M.D.	22b. ADDRESS Fenton, Mo.	22c. DATE SIGNED 1-15-60
---	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/16/60	23c. NAME OF CEMETERY OR CREMATORY James Grove Cem	23d. LOCATION (City, town, or county) (State) Murphysboro Ill
--	--------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Louis H. Bopp, Inc	25. DATE RECD. BY LOCAL REG. 1-16-60	26. REGISTRAR'S SIGNATURE Robert E Bauer
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 20 1961

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 Francis J. Weyland

Licensed Embalmer No. 4512

P. O. Address Kirkwood

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