

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JAN 15 1960**

**-60-003138**

# 2

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) a. STATE <b>Illinois</b> b. COUNTY <b>Sangamon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 weeks</b>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5744 Vivian Avenue</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2518 West Lake Shore Dr</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>M</b> Last <b>Becker</b>			4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1903</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Julius Moeller</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Franz</b>		14. NAME OF HUSBAND OR WIFE <b>deceased</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>Mrs. Ruth Hamlin, 539 Hickory Hollow Lane</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>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>many</b> <b>gas</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary arteriosclerosis</b>	
	DUE TO (c) <b>420.1</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 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.)	
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>12/1/59</b> to <b>1/1/60</b> and last saw her <b>alive</b> on <b>12/28/59</b> . Death occurred at <b>7: AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>M. D.</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>7205 W. Florent</b>		22c. DATE SIGNED <b>1/2/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal via Motor</b>	23b. DATE <b>Jan 2 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OakRidge Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield Illinois</b>	
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 2 - 1960</b>	26. REGISTRAR'S SIGNATURE <i>Lead Smith M.D.</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 Walter D. Beerside

Licensed Embalmer No. 4207

P. O. Address Spokane

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.