

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

EILED VS JAN 22 1960

-60-003311

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 467** STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St Louis	a. STATE Ill. b. COUNTY Medison		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI	Length of stay in 1b 6 days	c. CITY OR TOWN Collinsville	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 615 Victory Drive	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First ONA	Middle P.	Last DeVAULT	Month JANUARY	Day 13 Year 60
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-7-04	9. AGE (last birthday) 56
		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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Paducah Ky	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME C. N. Keebler	13b. MOTHER'S MAIDEN NAME Agnes Coe	14. NAME OF HUSBAND OR WIFE Elmer DeVault
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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) No	16. SOCIAL SECURITY NO. Unknwn	17. INFORMANT Elmer DeVault - 415 Victory Drive
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE		45 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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 **OCT. 27, 1959** to **JAN. 13, 1960** and last saw her/him alive on **JAN. 13, 1960**
 Death occurred at **5:05 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. O. Vermillion, M.D. (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/14/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1-17-60	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cem.	23d. LOCATION (City, town, or county) (State) Bellerive Ill.
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24. FUNERAL DIRECTOR Octroepfel ADDRESS 614 W Main Collinsville Ill	25. DATE RECD. BY LOCAL REG. JAN 14 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

HARRIS HOSPITAL

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 Paul C. Traman

Licensed Embalmer No. 2117

P. O. Address Collinsville

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.