

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004252

FILED VS FEB 5 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 812** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Alton	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 625 Mather Street	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First PAT Middle A. Last WISEMAN			4. DATE OF DEATH Month JANUARY Day 21 Year 1960			
5. SEX male	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 May 24, 1905	9. AGE (last birthday) 54 54	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) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Union Electric Co.		11. BIRTHPLACE (City and state or country) Plum Tree, N. Carolina USA		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Charles Wiseman		13b. MOTHER'S MAIDEN NAME Ida unknown		14. NAME OF HUSBAND OR WIFE Angela Wiseman		
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. 486-12-3024		17. INFORMANT Address Angela Wiseman, 625 Mather St.,		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERAL VASCULAR SHOCK, ETIOLOGY UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
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) OLD PULMONARY INFARCT. CARDIOMEGALY, ETIOLOGY UNKNOWN		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 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 **APRIL 4, 1949** to **JAN. 21, 1960** and last saw her/him alive on **JAN. 21, 1960**
 Death occurred at **10:35 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>C. D. Vermillion, M.D.</i>		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/22/60 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1-22-1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Memorial Park	23d. LOCATION (City, town, or county) Godfrey, Illinois		
24. FUNERAL DIRECTOR ADDRESS Gent Funeral Home, Alton, Illinois		25. DATE RECD. BY LOCAL REG. JAN 23 1960	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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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 Not Embalmed
J. H. [Signature]
Licensed Embalmer No. _____
P. O. Address St. Louis 7

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.