

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012297

STATE FILE NUMBER

FILED VS. MAR 31 1960

2 3197

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Belle ville	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Hospital		d. STREET ADDRESS 216 S. Pennsylvania	
3. NAME OF DECEASED (Type or print) First Middle Last LORNA Jean ALBERT		4. DATE OF DEATH Month Day Year March 18, 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1945
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (City and state or country) Belleville, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John C. Albert		14. NAME OF HUSBAND OR WIFE	
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. none	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEUKEMIA		17. INFORMANT Address John C. Albert 216 S. Penn.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) STAPHYLOCOCCAL SEPTICEMIA		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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NONE	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 3/14/60 to 3/18/60 and last saw her ^{her} _{from} alive on 3/18/60 Death occurred at 10:59 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James Pilling M.D.		22b. ADDRESS 1465 S. GRAND AVE.	
22c. DATE SIGNED 3/19/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-21-60	23c. NAME OF CEMETERY OR CREMATORY Marissa	23d. LOCATION (City, town, or county) (State) Marissa, Illinois
24. FUNERAL DIRECTOR Virgil W. Bergman		25. DATE RECD. BY LOCAL REG. MAR 19 1960	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Virginia A. DeGman
Licensed Embalmer No. 3697
P. O. Address Bellewille

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.