

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013197

FILED VS MAR 17 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 2638** 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 Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN Edwardsville 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) 110 E. Vandalia Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle ALICE Last SENN			4. DATE OF DEATH Month MARCH Day 3 Year 1960			
5. SEX Female	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 8/19/1912	9. AGE (last birthday) 47	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Waverly, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Ed Closterman		13b. MOTHER'S MAIDEN NAME May Ray		14. NAME OF HUSBAND OR WIFE Nelson		
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. 336-18-3807		17. INFORMANT Address Nelson Senn, Edwardsville, Ill.		

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) ANTERIOR CEREBRAL ANEURYSM WITH HEMORRHAGE		1 WEEK
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 **FEB. 27, 1960** to **MARCH 3, 1960** and last saw her/him alive on **MARCH 3, 1960**
Death occurred at **8:20 A.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 3/3/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-5-60	23c. NAME OF CEMETERY OR CREMATORY Sunset Hill Cemetery
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	23d. LOCATION (City, town, or county) (State) Madison Co., Ill.	25. DATE RECD. BY LOCAL REG. MAR 5 1960
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

no. 1

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AMERICAN EMBALMERS ASSOCIATION

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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: Harvey K. Kell

Licensed Embalmer No. 4591

P. O. Address St. Louis

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.

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