

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024455

FILED VS JUL 14 1960

318

1003

6645

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 <u>Illinois</u> b. COUNTY <u>St. Clair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>O'Fallon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR <u>St Louis Little Rock Hosp</u> INSTITUTION <u>Inc</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>112 W. Orchard</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Drake</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1883</u>	9. AGE (last birthday) <u>78</u>	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) <u>Loco Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>William Drake</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Copp</u>		14. NAME OF HUSBAND OR WIFE <u>Nora Anderson Drake</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>702,16,5150</u>		17. INFORMANT Address <u>Shirlee Corbier, 112 W. Orchard-O'Fallon,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u>							
DUE TO (c) <u>450.0</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility.</u>					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 type="checkbox"/> NO <input checked="" 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 <u>June 20, 1960</u> to <u>June 30, 1960</u> and last saw him <u>live</u> on _____ Death occurred at <u>2.05 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R C Treiman</u> (Degree or title) <u>MA</u>				22b. ADDRESS <u>1755 So Grand</u>		22c. DATE SIGNED <u>6-30-60</u>	
23a. BURIAL (Cremation, Removal, Specify) <u>Removal</u>		23b. DATE <u>7-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville, Ill.</u>		
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>JUN 30 1960</u>		26. REGISTRAR'S SIGNATURE <u>Karl Smith, M.D.</u>		

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

*Stanley F. Dixon*  
\_\_\_\_\_

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.