

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS

JUL 12 1960 318

1003

6476

-60-025142

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

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, MISSOURI		a. STATE Illinois	b. COUNTY Sangamon
Length of stay in 1b 12 days		c. CITY OR TOWN Illioopolis	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		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
GALE B. ZIRKLE			JUNE	24	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 6/10/1903	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) Tallula, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Travis Zirkle		13b. MOTHER'S MAIDEN NAME Marha Johnson	14. NAME OF HUSBAND OR WIFE Irene Zirkle		

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. Nil	17. INFORMANT Irene Zirkle, Illioopolis, Illinois.
---	---------------------------------------	--

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) CEREBRAL EDEMA AND SAGITTAL SINUS THROMBOSIS		2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) LEFT PARIETAL CRANIOTOMY	2 DAYS
	DUE TO (c) MENINGIOMA, LEFT PARIETAL LOBE OF BRAIN	UNKNOWN

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 type="checkbox"/> No <input type="checkbox"/> Unknown
	223X

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.) 223X
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 attested the deceased from **JUNE 12, 1960**, to **JUNE 24, 1960** and last saw her/him alive on **JUNE 24, 1960**
Death occurred at **1:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) JR Bealley M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/24/60
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/24/60	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	23d. LOCATION (City, town, or county) (State) Illioopolis, Illinois.
---	-----------------------------	---	--

24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington Blvd.,	25. DATE RECD. BY LOCAL REG. JUN 25 1960	26. REGISTRAR'S SIGNATURE Robert Smith M.D.
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

✓(H.T.)

STATE OF MISSISSIPPI

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 John J. Skaines
Licensed Embalmer No. 4108

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.