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1359

-61-006425

STATE FILE NUMBER
6425-61

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED VS FEB 20 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN E. St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1715 College	
3. NAME OF DECEASED (Type or print) First ADDIE Middle M. Last DOAK		4. DATE OF DEATH Month FEBRUARY Day 9 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. Marital Status Married Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXX		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) Bristol, Va.
13a. FATHER'S NAME Unknown Wray		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Wm. E. Doak
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	17. INFORMANT Wm. E. Doak Address 1715 College E. St. Louis, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 40 YEARS
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) BRONCHOPNEUMONIA, SUSPECTED			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 <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 JAN. 25, 1961 to FEB. 9, 1961 and last saw her alive on FEB. 9, 1961 Death occurred at 4:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>C. Vermillion, M.D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 2/10/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-12-61	23c. NAME OF CEMETERY OR CREMATORY Marissa City Cemetery	23d. LOCATION (City, town, or county) (State) Marissa, Illinois
24. FUNERAL DIRECTOR Chas. Burke ADDRESS E. St. Louis, Illinois		25. DATE RECD. BY LOCAL REG. FEB 10 1961	26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>

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 Shinton C. Spilliams

Licensed Embalmer No. 5016

P. O. Address Granite City, Ill.

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.