

SOUTH DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11296

-61-042431

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

STATE FILE NUMBER

AMENDED

DATE AWARDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

FILED DEC 12 1961

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		c. CITY OR TOWN Highland	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 621 9th St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Virgil Last Gilcrest Sr.			4. DATE OF DEATH Month December Day 3 Year 1961
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 10/5/1891
9. AGE (last birthday) 70		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) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (City and state or country) Licking, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Unknown Kilcrest	
13b. MOTHER'S MAIDEN NAME Unknown Rice		14. NAME OF HUSBAND OR WIFE Margret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		17. INFORMANT Address Roy V. Gilcrest Jr., Wellington, Kansas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia DUE TO (b) Thrombotic, left anterior cerebral artery DUE TO (c) Cerebral atherosclerosis. 3327			INTERVAL BETWEEN ONSET AND DEATH 8 months
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
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 May 21, 1961 to December 3, 1961 and last saw him alive on December 2, 1961 Death occurred at 04:30 am on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John T. Lawton, M.D.		22b. ADDRESS 634 N. Grand Blvd., St. Louis 3, Mo.	22c. DATE SIGNED Dec. 4, 1961
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-5-61	23c. NAME OF CEMETERY OR CREMATORY Carlyle Cemetery	23d. LOCATION (City, town, or county) (State) Carlyle, Ill.
24. FUNERAL DIRECTOR ADDRESS Harris Funeral Home, Highland, Ill.		25. DATE RECD. BY LOCAL REG. DEC 4 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 _____

Not Embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.