

1-4-41  
17-39  
X26390

State File No. ....

DEC 13 1941  
Registration District No. 750

Primary Registration District No. 200

Registrar's No. 2474

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lemay  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Mount St. Rose Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12/41 to 12/7/41  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 919

(c) City or town Chester 11  
(If outside city or town limits, write "RURAL")

(d) Street No. 1616 High St. 1  
(If rural, give location) 2

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME TERRELL, FRANK

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7  
year 1941 hour 6 minute — A. M.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife IDA TERRELL

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year) 1904

21. I hereby certify that I attended the deceased from Nov. 2, 1941 to Dec. 7, 1941  
that I last saw him alive on Dec. 4, 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years 37 Months ? Days ?  
If less than one day hr. min.

Immediate cause of death Far Advanced Pulmonary Tuberculosis 4 yrs.?

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Illinois

10. Usual occupation None

Due to 13 1/2

Due to \_\_\_\_\_

Other conditions Tbc Enteritis  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Terrell

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Reed

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital records

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof 12-7-41  
(burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Removal 102

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director Carbondale F Home

(b) Address Carbondale Ill

19. (a) DEC 7 1941 (b) C. Y. Mc Clanton  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Medew C. Henscott (M.D. or other) T

Address 607 No Grand Date signed 12/7/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 12 1948

1948  
55  
6904

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*John Ketter*  
Licensed Embalmer No. 3880

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 this body is not embalmed, fact should be so stated above.**