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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. 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>MAIDISON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>7 DAYS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>TROY</u>		9177 11	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S</u>				d. STREET ADDRESS (If rural, give location) <u>NR. NONE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>JOSEPH</u> c. (Last) <u>RIEGER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8 29 49</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, () WIDOWED, DIVORCED (Specify) <u>SINGLE INFANT</u>		8. DATE OF BIRTH <u>AUG. 20-1949</u>	
9. AGE (In years last birthday) _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>HIGHLAND ILLINOIS</u>	
11. BIRTHPLACE (State or foreign country) _____		12. CITIZEN OF WHAT COUNTRY? _____					
13a. FATHER'S NAME <u>JOSEPH G. RIEGER</u>			13b. MOTHER'S MAIDEN NAME <u>DEBORES HOLSHOUSER</u>			14. NAME OF HUSBAND OR WIFE <u>SINGLE</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>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joseph G. Rieger</u> ADDRESS <u>Troy, Illinois</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>occlusion of The Duodenum</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>occlusion of the Duodenum</u> DUE TO (c) <u>same</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
19a. DATE OF OPERATION <u>8-29-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>complete occlusion a Duodenum</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>1226</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5410</u>			
22. I hereby certify that I attended the deceased from <u>Aug 23, 1949</u> to <u>Aug 28, 1949</u> , that I last saw the deceased alive on <u>8-29-49, 1949</u> , and that death occurred at <u>11:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George Morris M.D.</u>				23b. ADDRESS <u>St. John's Hospital</u>		23c. DATE SIGNED <u>8-30-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>AUG 30 1949</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>TROY ILLINOIS</u>	
DATE REC'D BY LOCAL _____		REGISTRAR'S SIGNATURE <u>J. Blaser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald S. Edwards</u>		ADDRESS <u>Troy Illinois</u>	

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

7572

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.....

NOT EMBALMED

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *James L. Edwards*

Licensed Embalmer No. *35-48*

P. O. Address *Ing Illinois -*

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.