No. 300
10.48

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31686

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8000

1. PLACE OF DEATH
a. COUNTY —
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (In this place) 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Barnes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Illinois
b. COUNTY Macoupin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bird Township
d. STREET ADDRESS (If rural, give location) N.R.

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Walton c. (Last) Costello

4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 10, 1881
9. AGE (In years last birthday) 68 — If under 1 year: Months, Days; If under 1 hr.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bird Township, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE William Costello

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Costello, Bird Twnsp., Ill.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH 60 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Op. for Carcinoma of rectum

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Sept 7, 1949
19b. MAJOR FINDINGS OF OPERATION Carcinoma of rectum
20. AUTOPSY? YES ☐ NO ☒

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) 46

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 1.54X

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949, *to* Sept. 14, 1949, *that I last saw the deceased alive on* Sept. 14, 1949, *and that death occurred at* 11:55 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) F.R. Bradley M.D.
23b. ADDRESS Barnes Hospital
23c. DATE SIGNED 9/14/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 9-15-49
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Carlinville, Ill.

DATE REC'D BY LOCAL REG. SEP 15 1949
REGISTRAR'S SIGNATURE J.B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd

(Licensed Embalmer's Statement on Reverse Side)

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

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 .....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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