

THE DIVISION OF HEALTH OF THE STATE OF ILLINOIS
STANDARD CERTIFICATE OF DEATH

29530

State File No.
Registrar's No. 7588

FILED AUG 23 1952

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE ILLINOIS b. COUNTY 8120	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) 2 WEEKS	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge		d. STREET ADDRESS (If rural, give location) 603 West Douglas	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle)	c. (Last) Guida	4. DATE OF DEATH (Month) (Day) (Year) 8-4-52
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10-2-1890	9. AGE (In years last birthday) 61	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (City and State or Foreign Country) Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Guida	13b. MOTHER'S MAIDEN NAME Nolo	14. NAME OF HUSBAND OR WIFE Unknown
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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. 355-09-1446	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Boncorosi - West Frankfort
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aneurysm Ascending Aorta Unknown		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cardiac Asystole		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION Aug 4, 1952	19b. MAJOR FINDINGS OF OPERATION Aneurysm ascending aorta	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo.
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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? 451X
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22. I hereby certify that I attended the deceased from **Aug 2, 1952**, to **Aug 4, 1952**, that I last saw the deceased alive on **Aug 4, 1952**, and that death occurred at **11:20** a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph L Lucido MD	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 8/8/52
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24a. BURIAL, CREMATION REMOVAL (where)	24b. DATE 58-6-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) West Frankfort Ill.
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DATE REC'D BY LOCAL REG. AUG 9 1952	REGISTRAR'S SIGNATURE Paul Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Union - West Frankfort, Ill
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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 M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis Mo.

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.