

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

State File No. **32714**
8548

FILED OCT 1 1952

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN E. Alton 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's		d. STREET ADDRESS (If rural, give location) 123 Bender	

3. NAME OF DECEASED (Type or Print) a. (First) David b. (Middle) William c. (Last) Baker			4. DATE OF DEATH (Month) (Day) (Year) 9 11 1952			
5. SEX m	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 8-14-49	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Alton, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Betz Baker	13b. MOTHER'S MAIDEN NAME Lois W. Read	14. NAME OF HUSBAND OR WIFE -
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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 JOHN BAKER - ALTON ILL.
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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, asphyxia, 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) Cranio-pharyngioma		3yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 9-9-52	19b. MAJOR FINDINGS OF OPERATION Increased Intra-cranial Pressure	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 224X

22. I hereby certify that I attended the deceased from **9-9-1952** to **9-11-1952**, that I last saw the deceased alive on **9-11-1952**, and that death occurred at **7 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE John C. Herweg M.D. (Degree or title)	23b. ADDRESS Bluebeams Drap	23c. DATE SIGNED 9-11-52
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 9-11-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) ALTON - ILL.
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DATE REC'D BY LOCAL REG. SEP 11 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE GENT - ALTON	ADDRESS ALTON ILL.
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mgs (Licensed Embalmer's Statement on Reverse Side)

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

Sum in preliminary of and always

DEC 13 1961

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 W. E. Eubank

Licensed Embalmer No. 1000

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.