

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7597

FILED FEB 26 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1586**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Granite City 8120	
c. LENGTH OF STAY (In this place) 1 Day		d. STREET ADDRESS (If rural, give location) RR #1 Box 16 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Betty b. (Middle) Jean c. (Last) Hale			4. DATE OF DEATH (Month) (Day) (Year) Feb. 10 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	
8. DATE OF BIRTH Jan. 24, 1952		9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Jonesboro, Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Oren E. Hale		13b. MOTHER'S MAIDEN NAME Juanite Pearson		14. NAME OF HUSBAND OR WIFE	
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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. None		17. INFORMANT'S SIGNATURE OR NAME Oren E. Hale RR#1 Granite City, Ill	
ADDRESS					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Measles			
		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		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		
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?		

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:55 A** m., from the causes and on the date stated above.

23. SIGNATURE Patrick L. Taylor Cur 3 (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 2. 10. 53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 10, '53		24c. NAME OF CEMETERY OR CREMATORY City Cemetery	
		24d. LOCATION (City, town, or county) (State) Steele Missouri			

DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE FEB 10 1953		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Frank Mercer	
				ADDRESS Granite city Ill	

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 Charles E Mercer

Licensed Embalmer No. 2988

P. O. Address Shreve City

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.