

FILED FEB 18 1955

THE DIVISION OF HEALTH OF ILLINOIS
STANDARD CERTIFICATE OF DEATH

State File No. 5097
Registrar's No. 410

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ILLINOIS b. COUNTY McLEAN

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY c. LENGTH OF STAY (in this place) 3 MO.

c. CITY OR TOWN BLOOMINGTON d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARYS HOSPITAL

STREET ADDRESS (If rural, give location) 1003 North Morris Ave. 8120

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) P. c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) JAN. 27, 1955

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 5-1873

9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 11 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer

10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery

11. BIRTHPLACE (City and State or Foreign Country) Joliet, Illinois 1

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Smith

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Mrs. Agnes Gillian Smith

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 ADDRESS John H. Smith---son-Kansas City, Ks

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.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease
Generalized Arteriosclerosis
DUE TO (b)
DUE TO (c) Generalized Colitis
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
5 yrs.
15 yrs.
443 X

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 18, 1955 to Jan 28, 1955, that I last saw the deceased alive on Jan 27, 1955 and that death occurred at 6-8 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank A. O'Connell M.D.

23b. ADDRESS 327 Angyle Bldg 23c. DATE SIGNED 1/28/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 1/28/55

24c. NAME OF CEMETERY OR CREMATORY St. Marys

24d. LOCATION (City, town, or county) (State) Bloomington, Illinois

DATE REC'D BY LOCAL REG. 1-28-55 REGISTRAR'S SIGNATURE Neva Munsell

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Quirk & Tobin-20 W. Linwood, K.C. Mo.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Frank A. O'Connell

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *Forrest D. Coldman*

Licensed Embalmer No. *4714*

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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