

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

358861

STATE FILE NUMBER

FILED OCT 16 1956

Registration District No.

318

Primary Registration District No. 1003

Registrar's No.

8839

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN W. Frankfort		8120 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge			Length of stay in 1b		d. STREET ADDRESS 815 W. Worden		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) VIRGINIA				First Middle Last MC KEMIE		4. DATE OF DEATH 9-23-56		Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1926		9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 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 at home	11. BIRTHPLACE (City and state or country) Marion, Ill.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME W. B. Groves				14. MOTHER'S MAIDEN NAME Bessie Rice					
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 Stone F. Home, W. Frankfort, Ill.				Address	
18. CAUSE-OF DEATH-[Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS							INTERVAL BETWEEN ONSET AND DEATH 15 min		
Conditions, if any, which gave rise to above cause, (a), stating the underlying cause last.		DUE TO (b) SUBACUTE BACTERIAL ENDOCARDITIS		DUE TO (c) Non-hemolytic Staphylococcus 4011		2 MO.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease with Aortic and Mitral Valvulitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from Sept 5, 1956 to Sept. 23, 1956 and last saw her alive on Sept. 23, 1956 Death occurred at 4 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Hubert B. Sweet, M.D.				22b. ADDRESS 509 N. GRAND ST. LOUIS, MO.		22c. DATE SIGNED 9/25/56			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9-24-56	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) West Frankfort, Ill.				
24. FUNERAL DIRECTOR Stone, West Frankfort, Ill.				ADDRESS		25. DATE RECD. BY LOCAL REG. SEP 25 1956		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Health, welfare, public service

000-56

Causes of death must be stated in Part I. If the cause of death is a natural cause, the cause must be stated in Part I. If the cause of death is a disease, the cause must be stated in Part I. If the cause of death is an injury, the cause must be stated in Part I. If the cause of death is a poisoning, the cause must be stated in Part I. If the cause of death is a disease, the cause must be stated in Part I. If the cause of death is an injury, the cause must be stated in Part I. If the cause of death is a poisoning, the cause must be stated in Part I.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....
Signature of Student Embalmer

Signed *W E Morris*.....

Licensed Embalmer No. *3*.....

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING,
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.