

Health, Welfare, Public Service

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 Doctor, coroner, etc. must use only standard form. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED FEB 25 1957

318

1003

STATE FILE NUMBER

6221

1068

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Adams	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR ST. LOUIS, MO. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Quincy 81208 Inside Limits 32 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb 04 HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Reside on Farm 2635 Main Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BETTY		4. DATE OF DEATH Month FEB Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 11, 1920
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician	11. BIRTHPLACE (City and state or country) Chicago, Illinois,
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Medical Clinic	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Laurence Bremser		14. MOTHER'S MAIDEN NAME Mildred Wall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 324-14-2329	17. INFORMANT Address Mrs. Mildred Bremser, Quincy, Illinois,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANEURYSM OF BASILAR ARTERY WITH ADJACENT THROMBOSIS DUE TO (b) HYPERTENSION DUE TO (c) 330.X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input 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 JAN. 28, 1957 to FEB. 1, 1957 and last saw her alive on FEB. 1, 1957 Death occurred at 12:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. J. Remellia, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 2/1/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-1-57	23c. NAME OF CEMETERY OR CREMATORY Local
23d. LOCATION (City, town, or county) (State) Quincy, Illinois,			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,		25. DATE RECD. BY LOCAL REG. FEB 2 '57	26. REGISTRAR'S SIGNATURE J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 *J. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *Row*

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.