

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26484

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6868**

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair			
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 LINSBURG 8120		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION MARIAN Hosp.			Length of stay in 1b 3 wks		d. STREET ADDRESS (If outside, give location) 32 None		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HASEY Middle Last REA				4. DATE OF DEATH Month 7 Day 23 Year 57			
5. SEX MALE	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 2-3-1894		9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES		11. BIRTHPLACE (City and state or country) CHRISTOPHER, ILL		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM REA				14. MOTHER'S MAIDEN NAME Jolie Plumlee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW I Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Arlin Rea 517 E. 17th Rd. Belleville, Ill.			
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 Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Cholelithiasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH July 22-57 1 month	
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 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 June 27-57 to July 22-1957 and last saw her alive on July 22-1957 Death occurred at 12:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE H. G. Moore MD (Degree or title)				22b. ADDRESS 917-5018		22c. DATE SIGNED July 23-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7-23-57	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) DeQuoin Ill.		
24. FUNERAL DIRECTOR Schroeder			ADDRESS DeQuoin, Ill.		25. DATE RECD. BY LOCAL REG. JUL 23 57	26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

H. G. Monte

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Frank Brown

Licensed Embalmer No.....

P. O. Address.....

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.