

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 33401

Registrar's No. 8193

| | | | | | | | | | | | |
|--|--|--|---|---|---|---|------------------------|-------------------------------------|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | State File No. 33401 | | Registrar's No. 8193 | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) 11 days | | c. CITY OR TOWN East St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge | | | | e. STREET ADDRESS 729 N. 26th. | | f. (If rural, give location) 81208 | | | | | |
| 3. NAME OF DECEASED (Type or Print) John DeFosset | | | a. (First) | | b. (Middle) | | c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 31, 1957 | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH April 30, 1890 | | 9. AGE (In years last birthday) 67 | | 10. IF UNDER 1 YEAR Months _____ Days _____ | 11. IF UNDER 18 HRS. Hour _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Ripley, Ohio | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME Christopher DeFosset | | | 13b. MOTHER'S MAIDEN NAME Elizabeth (not known) | | | 14. NAME OF HUSBAND OR WIFE | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME Vernon DeFosset | | | | | | ADDRESS Belleville, Ill |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 HO. | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ADENOCARCINOMA OF COLON WITH CEREBRAL METASTASIS. | | | | | | | |
| | | | | ANTECEDENT CAUSES | | | | | | | |
| | | | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | |
| | | | | DUE TO (b) _____ | | | | | | | |
| | | | | 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 None | | 19b. MAJOR FINDINGS OF OPERATION None | | | | | | | | 20. AUTOPSY? YES <input checked="" 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 8-29, 1957, to 8-31, 1957, that I last saw the deceased alive on 8-31, 1957, and that death occurred at 11:55 P.M., from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Dr. W. H. Kennedy, M.D. | | | | 23b. ADDRESS 1225 So. Grand Blvd. | | | | 23c. DATE SIGNED 8-31-57 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Sept. 4, 1957 | | 24c. NAME OF CEMETERY OR CREMATORY Holy Cross | | 24d. LOCATION (City, town, or county) St. Clair Co., Ill | | (State) _____ | | | |
| DATE REC'D BY LOCAL REG. SEP 3 1957 | | REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | | | 25. HEALTH DIRECTOR'S SIGNATURE (Licensed Embalmer's Statement on Reverse Side) W. H. Burke | | ADDRESS East St. Louis | | | | |

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.....
Signature of Student Embalmer

Signed.....
Chas Bense

Licensed Embalmer No... 2421

P. O. Address... East St. Lou.

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.