

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

37421

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **9721**

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Taylorville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 804 W. Market	
3. NAME OF DECEASED (Type or print) First THOMAS Middle NMN Last FISH		4. DATE OF DEATH Month OCT. Day 16, Year 1957	
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 Sept. 12, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (City and state or country) Effingham, Illinois
13a. FATHER'S NAME Thomas Fish		13b. MOTHER'S MAIDEN NAME Sarah Howard	14. NAME OF HUSBAND OR WIFE Ruby
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. 348-03-8958	17. INFORMANT Address Ruby Fish Taylorville, 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) QUESTIONABLE CEREBRAL EMBOLUS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) MYOCARDIAL INFARCTION DUE TO (c) 4201			INTERVAL BETWEEN ONSET AND DEATH 9 DAYS 9 DAYS
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 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 <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 OCT. 2, 1957 to OCT. 16, 1957 and last saw her alive on OCT. 16, 1957 Death occurred at 5:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carl Smith M.D.</i> (Degree or title)		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10-17-57	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Edinburgh, Illinois
24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. OCT 17 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *John J. Haines*

Licensed Embalmer No. *4108*

P. O. Address *St. Louis, 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.