

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46169
STATE FILE NUMBER
12019

FILED DEC 20 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12019

S. 300
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Belleville</u> ^{12⁰} ₈		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b <u>12 days</u>	d. STREET ADDRESS <u>820 North 39th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LELIA</u> Middle <u>NM</u> Last <u>NORMINGTON</u>			4. DATE OF DEATH <u>DECEMBER 12, 1957</u> Month <u>12</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1923</u>	9. AGE (In years last birthday) <u>34</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Stearns, Ky.</u>	
13a. FATHER'S NAME <u>Everett Ballou</u>			13b. MOTHER'S MAIDEN NAME <u>not known</u>		14. NAME OF HUSBAND OR WIFE <u>Ralph Normington</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ralph Normington</u> Address <u>Belleville, Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HISTOPLASMOSIS, DISSEMINATED</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <u>134-2</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PANCYTOPENIA, 10 MONTHS</u>					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 _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> 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 <u>NOV. 30, 1957</u> to <u>DEC. 12, 1957</u> and last saw her alive on <u>DEC. 12, 1957</u> Death occurred at <u>9:25 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. E. Vermillion, M.D.</u> M. D.			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>12/13/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>12/16/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Williamson, W. Va.</u>		23d. LOCATION (City, town, or county) <u>Williamson, W. Va.</u> (State)
24. FUNERAL DIRECTOR <u>Alton Belluck</u> ADDRESS <u>Belleville, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 14 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.	

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. A. L...*

Licensed Embalmer No. *3697*

P. O. Address *Bellville*

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.