Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-042372
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10543

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS, MISSOURI — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: VAH, 915 N. GRAND AVE. — Length of stay in Hospital: 138 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ILLINOIS
b. COUNTY
c. CITY OR TOWN: EFFINGHAM — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 405 NO. OAK — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First CECIL Middle G. Last VAN DYKE
4. DATE OF DEATH: Month 11 Day 3 Year 58
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 4/10/95
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): MASON, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: JOHN T. VAN DYKE
13b. MOTHER'S MAIDEN NAME: EMMA WOODWARD
14. NAME OF HUSBAND OR WIFE: VERA VAN DYKE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: 346-20-8648
17. INFORMANT: VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 14 HRS
DUE TO (b) MULTIPLE MYELOMA — 6MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (c) 203 X
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 [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 6/18/58, to 11/3/58 and last saw him alive on 11/3/58
Death occurred at 2:50 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: B. W. JUSTUS (Degree or title): M.D.
22b. ADDRESS: VAH, ST. LOUIS, MISSOURI
22c. DATE SIGNED: 11/3/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-4-58
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county): Effingham (State): Illinois

24. FUNERAL DIRECTOR: Johnson ADDRESS: Effingham, Ill.
25. DATE RECD. BY LOCAL REG.: NOV 5 '58
26. REGISTRAR'S SIGNATURE: Earl Smith MD MGB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Frank Prokopf

Licensed Embalmer No. 4356

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.