

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006903

STATE FILE NUMBER
2128

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

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>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Granite City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>		Length of stay in 1b	d. STREET ADDRESS <u>4803 Kirkpatrick Homes</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tillie Mageline Besserman</u>			4. DATE OF DEATH Month Day Year <u>March 1, 1959</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 checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1924</u>
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 <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Graham Ky.</u>
13a. FATHER'S NAME <u>Walter Gibson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</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.	17. INFORMANT <u>Granite City Ill. John W. Lee 4803 Kirkpatrick Homes</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>Septicemia - Bacteriemia - Diabetes</u> DUE TO (b) <u>Para Rectal abscess - cellulitis</u> DUE TO (c) <u>260x</u> 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
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 <u>Feb. 19</u> to <u>March</u> and last saw her alive on <u>3-1-59</u> Death occurred at <u>6:30 3/1/59</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Geo. H. Blaine M.D.</u>		22b. ADDRESS <u>3720 Starbuck Ave.</u>	22c. DATE SIGNED <u>3/2/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Madison Co. Ill.</u>	23d. LOCATION (City, town, or county) (State) <u>Edwardsville Twp. Illinois.</u>
24. FUNERAL DIRECTOR <u>Thomas J. Farley</u>		ADDRESS <u>Madison, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 2 '59</u>
26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Francis J. Faherty*

Licensed Embalmer No. *279*
P. O. Address *Madison*

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.