

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011125
STATE FILE NUMBER
2-2067

MAR 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
32
7X
0
8

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>MADEISON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ALTON</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St LUKES Hosp</u>		Length of stay in lb <u>1904</u>	d. STREET ADDRESS (If outside, give location) <u>823 FRANKLIN AVE</u>		Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BIRDIE BALES LEE</u>			4. DATE OF DEATH Month Day Year <u>2-26-59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22-1904</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>- - - -</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gift Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. J. Jacoby Co</u>		11. BIRTHPLACE (City and state or country) <u>ROSE HILL, VA!</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13a. FATHER'S NAME <u>WILLIAM LOVENS</u>		13b. MOTHER'S MAIDEN NAME <u>DOAA BALES</u>	
14. NAME OF HUSBAND OR WIFE <u>_____</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If no, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>337-18-3573</u>	
17. INFORMANT Address <u>Mary Neal Melford 823 Franklin</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>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Recurrent Carcinoma Pharynx</u> DUE TO (c) <u>Carcinoma of Pharynx</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>148X</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mths</u> <u>8 yrs</u>		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 WORK <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>Sept 1958</u> to <u>2-26-59</u> and last saw her alive on <u>2-26-59</u> Death occurred at <u>12:30 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>3770 Woodway Ln</u>		22c. DATE SIGNED <u>2/27/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2028-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA</u>		23d. LOCATION (City, town, or county) (State) <u>ALTON ILL.</u>
24. FUNERAL DIRECTOR <u>Olson Quinn Co. 3 Henry</u>		ADDRESS <u>Alton Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 27 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u> S.P.					

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 *Olason Quinn*

Licensed Embalmer No. *E. 5996*
P. O. Address *Alton Ill.*

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.