

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014405

STATE FILE NUMBER

FILED APR 23 1959

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 55

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY SCOTT	
b. CITY OR TOWN LOUISIANA		c. CITY OR TOWN WINCHESTER	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PIKE CO. HOSP		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First Middle Last HERMAN THEODORE HIERONYMUS			4. DATE OF DEATH Month Day Year APRIL 20, 1959		
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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 AUG 12, 1887	9. AGE (In years less birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working years, even if not in same industry) OPERATOR - GRAIN ELEVATOR	10b. KIND OF BUSINESS OR INDUSTRY MT. OLIVE, ILLINOIS	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CHARLES HIERONYMUS	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MAE HIERONYMUS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES W.W.I.	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT MAE HIERONYMUS, WINCHESTER, ILL.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach		INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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? 151X 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from 3. 5. 59 to 4. 20. 59 and last saw her/him alive on 4. 20. 59 . Death occurred at 11.30 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G. R. Ryan M.D.	22b. ADDRESS Louisiana Mo.	22c. DATE SIGNED 4/20/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE APRIL 20, 1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) WINCHESTER, ILL.
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24. FUNERAL DIRECTOR GUNNINGHAM FUNERAL HOME	25. DATE RECD. BY LOCAL REG. APRIL 20-1959	26. REGISTRAR'S SIGNATURE Bernice Collier
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WINCHESTER ILLINOIS

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Geo. M. Callahan*

Licensed Embalmer No. *3839*
P. O. Address *Houston*

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.