

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023170

STATE FILE NUMBER

25547

FILED JUN 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar No. \_\_\_\_\_

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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 cause related. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
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>JACKSONVILLE</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>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>442 So. MAUVAISTERRE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>J.</u> Last <u>MAGILL</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1879</u>
9a. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 1st birthday) Months Days Hours Min. <u>80</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>LAFFYETTE LAMKE</u>		13b. MOTHER'S MAIDEN NAME <u>MARYJANE THOMPSON</u>	14. NAME OF HUSBAND OR WIFE <u>OWEN MAGILL</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>OWEN MAGILL</u> Address <u>JACKSONVILLE ILL.</u> <u>442-50 MAUVAISTERRE</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>pyloric obstruction</u> <u>chr duodenal ulcer</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Arteriosclerosis of the aorta</u> DUE TO (c) <u>541.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerosis, generalized</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 <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>7 June 59</u> to <u>9 June 59</u> and last saw her alive on <u>9 June 59</u> Death occurred at <u>6:35 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Eugene M. Bricker</u> (Name or title) <u>M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>6/10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JUNE 10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EAST CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>JACKSONVILLE ILL.</u>
24. FUNERAL DIRECTOR <u>C.R. Lupton &amp; Sons</u> ADDRESS <u>7233 DELMAR BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 10 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>

M.D.

STATEMENT BY LICENSED EMBALMER

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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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

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.