

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023447

STATE FILE NUMBER

FILED JUL 1 1959

Registration District No.

Primary Registration District No.

Registrar's **8** 5836

S. 300
v. 1-57
36
7 I

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Shelby	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Mode Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's		Length of stay in lb 7 days	d. STREET ADDRESS (If outside, give location) Box 24 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Olin Last Syfert			4. DATE OF DEATH Month June Day 17 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 10yrs IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) Shelbyville, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Olin Eroy Syfert		13b. MOTHER'S MAIDEN NAME Dorothy Whitwell	
14. NAME OF HUSBAND OR WIFE never married		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Jane Henrichsen-500 S. Kingshighway Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema; congestion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Post-op repair (open-heart), correction of aortic valve DUE TO (c) CHD - ostium primum, deformed mitral v.			INTERVAL BETWEEN ONSET AND DEATH 9 min 26 hrs. hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7545			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 6/11/59 to 6/17/59 and last saw her/him alive on 6-17-59 Death occurred at XXXXXX 5:30pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Richard Spiess M.D. (Name or title)		22b. ADDRESS 500 S. Kingshighway	
22c. DATE SIGNED 6-17-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6-18-1959	23c. NAME OF CEMETERY OR CREMATORY HOCAI
23d. LOCATION (City, town, or county) Shelbyville, Ill.		(State)	
24. FUNERAL DIRECTOR Kessler-Howe, Shelbyville, Ill.		25. DATE RECD. BY LOCAL REG. JUN 19 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

mjb

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 *Clarence M. Billo*
Licensed Embalmer No. *4375*
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.