

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025876

FILED VS AUG 7 1959

STATE FILE NUMBER

Registration District No. 203 Primary Registration District No. 3040 Registrar's No. 203

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>2 Days</u>	c. CITY OR TOWN <u>Chicago</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>611 Madison</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>MUTCHER</u> Last <u>MUTCHER</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1911</u>	9. AGE (last birthday) <u>48</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Gang</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME <u>John Mutchek</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Cigola</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>Unknown</u>		16. SOCIAL SECURITY NO. <u>322-18-0282</u>	17. INFORMANT <u>Records Bldg. Railroada Chillicothe, Mo</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>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.	Month, Day, Year _____				
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>none</u> to <u>him</u> and last saw <u>him</u> alive on <u>July 30-59</u> Death occurred at <u>1:15 P.</u> on the date stated above, and to the best of my knowledge from the causes stated.					
22a. SIGNATURE <u>Joseph A. Conrad</u> (Degree or title) <u>Coroner M.D.</u>		22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>July 31-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City, town, or county) (State) <u>West Frankfort, Ill</u>	
24. FUNERAL DIRECTOR <u>Keeny-Lindley Funeral</u>		ADDRESS <u>H. Chillicothe, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7/31/59</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Hall</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 24 1959

NOV 18 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*B. J. Ludley*

Licensed Embalmer No. 4822

P. O. Address Chillicothe

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.