

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026290

FILED VS JUL 20 1959 310

Registration District No.

Primary Registration District No.

3058

Registrar's No.

171

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Charles			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Calhoun		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in lb	c. CITY OR TOWN Road District # 5		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Last Stein			4. DATE OF DEATH Month July Day 15 Year 1959		
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 9/19/1882	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) Golden Eagle, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Stein		13b. MOTHER'S MAIDEN NAME Elizabeth Reinecke		14. NAME OF HUSBAND OR WIFE Elizabeth Kary	
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. 331-32-4335		17. INFORMANT Paul Stein, Golden Eagle, Ill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia bilateral lobes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular Disease - ? DUE TO (c) Hernia, inguinal incarcerated ? years					INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If 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 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 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 July 14, 1959 to July 15, 1959 and last saw him alive on July 15, 1959 Death occurred at 12:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Russell Glider, M.D.			22b. ADDRESS St Charles, Mo.		22c. DATE SIGNED July 16, 1959
23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE July 18, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Brussels, Ill.	
24. FUNERAL DIRECTOR H.A. Imming, Brussels, Illinois			25. DATE RECD. BY LOCAL REG. July 16 - 59		26. REGISTRAR'S SIGNATURE Marcella Wilson

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 

Licensed Embalmer No. 483

P. O. Address St. Charles

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.