

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026400

FILED JUL 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 6334** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 3 Months	c. CITY OR TOWN Pekin Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1022 Washington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JENNIE NMN BELT			4. DATE OF DEATH Month Day Year JULY 4, 1959			
5. SEX F.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1896	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Sidney, Indiana	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Samuel Fisher		13b. MOTHER'S MAIDEN NAME Olive (unknown)		14. NAME OF HUSBAND OR WIFE Walter Belt		
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 Address Walter Belt, 1022 Washington, Ill. Pekin			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
IMMEDIATE CAUSE (a) Intestinal Obstruction		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cystadenocarcinoma of the ovary	
DUE TO (c)		1 year

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 3/15/58 to 7/4/59 and last saw her ^{her} _{him} alive on 7/4/59 Death occurred at 1:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>C. O. Vermillion, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS Barnes Hospital	22c. DATE SIGNED 7/4/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (auto)	23b. DATE 7/5/1959	23c. NAME OF CEMETERY OR CREMATORY Elkhardt Cem.	23d. LOCATION (City, town, or county) Elkhardt, Indiana
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24. FUNERAL DIRECTOR Abts Mortuary, Pekin, Ill.	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 5 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATE OF NEW YORK
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
ALBANY, NEW YORK

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 Joseph E. McCullough
Licensed Embalmer No. 246

P. O. Address 617 5th

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.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
ALBANY, NEW YORK