

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 13 1959**

**59-026519**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 7208** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>				Length of stay in 1b		c. CITY OR TOWN <b>Lovejoy, Illinois</b>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Peoples Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>705 Adams Street</b>		
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle Last <b>COTTON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31,</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/24/1893</b>		
				9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days		
						IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (City and state or country) <b>DesArc, Arkansas</b>		
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13a. FATHER'S NAME <b>WILLIAM LEWIS</b>		13b. MOTHER'S MAIDEN NAME <b>SMITHRIE COLEY</b>		14. NAME OF HUSBAND OR WIFE <b>DECEASED.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>705 Adams, Lovejoy</b> <b>Laverne Dorothy Hill, Daughter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Hypertensive Heart Disease</b> DUE TO (b) <b>443x</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>6 mos (Heart)</b>	
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		
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 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 <b>7-24-59</b> to <b>7-31-59</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>7-31-59</b> Death occurred at <b>Peoples Hospital 6:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W. A. Singel M.D.</b> Degree or title				22b. ADDRESS <b>1652 Central Ave. E. St. Louis, Ill.</b>		22c. DATE SIGNED <b>5-9-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/31/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens of Memory</b>		23d. LOCATION (City, town, or county) (State) <b>Stokey Township, Illinois</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Marionto Officer 2114 Missouri E. St. Louis, Ill.</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 4 '59</b>		26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*7180*

**STATEMENT BY LICENSED EMBALMER**

*not embalmed*

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 *Eddie Halling*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.