

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS AUG 13 1959**

**59-026543**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7252**

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 <del>XXXXXXXXXX</del> St. Louis		Length of stay in lb oda.	c. CITY OR TOWN Flatrock
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R. R. # 1

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Jack	Lee	Decker		8	4	59

5. SEX male	6. COLOR OF HAIR W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/10-48	9. AGE (last birthday) 11yr	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
----------------	-----------------------	---	-----------------------------	--------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Knox County, Ind.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	---------------------------------------

13a. FATHER'S NAME Harry Franklin Decker	13b. MOTHER'S MAIDEN NAME Ethel Booker	14. NAME OF HUSBAND OR WIFE none
---	---	-------------------------------------

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 Georgia Lapp-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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		5 minutes
DUE TO (b) <i>3rd Degree Burns 50%</i>		5 weeks
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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 1b.) EXPLOSION - F. TRACTOR - FUEL -
---	--	---

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.) AT HOME - IN - FLATROCK - ILL - ON	20f. CITY, TOWN, OR LOCATION ORADUET - 7127159	COUNTY	STATE
---	--	--	---	--------	-------

21. I attended the deceased from <u>7-27-59</u> to <u>8-4-59</u> and last saw him alive on <u>8-4-59</u> . Death occurred at <u>10:30</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Leonard Peter Rome</i> (Degree or title) M.D.	22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 8-4-59
---	-------------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/5/59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) Lawrenceville, Illinois
--	---------------------	------------------------------------	--

24. FUNERAL DIRECTOR <i>John Hassley</i>	ADDRESS Ill. East St. Louis,	25. DATE RECD. BY LOCAL REG. AUG 5 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
---	---------------------------------	---	--

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 Not Embalmed, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Joseph J. Karsly

Licensed Embalmer No. 7541

P. O. Address E. H. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.