

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 17 1959

59-026858

STATE FILE NUMBER

2 6392

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

DEED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>  c. CITY OR TOWN <b>Cottage Hills</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>164 Neunaber</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARIE</b> Middle <b>MAY</b> Last <b>KRAMER</b>			<b>4. DATE OF DEATH</b> Month <b>JULY</b> Day <b>2</b> Year <b>1959</b>		
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/27/1925</b>	<b>9. AGE</b> (last birthday) <b>33</b> IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> At Home.		<b>11. BIRTHPLACE</b> (City and state or country) <b>Greenfield, Illinois.</b>	
<b>13a. FATHER'S NAME</b> Arthur Roberts		<b>13b. MOTHER'S MAIDEN NAME</b> Clara Buck		<b>14. NAME OF HUSBAND OR WIFE</b> Texas Kramer	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		<b>16. SOCIAL SECURITY NO.</b> Unknown		<b>17. INFORMANT</b> Address <b>Texas Kramer, Cottage Hill, Illinois.</b>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PHLEBOTROMBOSIS</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>FEW MINUTES</b>  <b>UNKNOWN</b>
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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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____		

21. I attended the deceased from **MAY 30, 1959** to **JULY 2, 1959** and last saw her <sup>him</sup> alive on **JULY 2, 1959**  
 Death occurred at **6:25 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>E. D. Nemillia, M.D.</i>	<b>22b. ADDRESS</b> <b>BARNES HOSPITAL</b>	<b>22c. DATE SIGNED</b> <b>7/3/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Removal	<b>23b. DATE</b> <b>7-5-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Woodland Hills Cemetery	<b>23d. LOCATION</b> (City, town, or county) (State) Wood River, Illinois.
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<b>24. FUNERAL DIRECTOR</b> ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.	<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 5 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Carl Smith, M.D.</i>
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Spec. of - no maternal death

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjb*

**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 Stanley H. Dejo

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.