

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026910

FILED VS AUG 4 1959

Primary Registration District No.

Registrar's No.

2 6827

STATE FILE NUMBER

FILED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b		c. CITY OR TOWN <u>Woodriver</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>361 Penning</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>L.</u> Last <u>McGHEE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1939</u>		9. AGE (last birthday) <u>20</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24-HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>East Alton, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Roy McGhee</u>				13b. MOTHER'S MAIDEN NAME <u>Velma Logsdon</u>				14. NAME OF HUSBAND OR WIFE <u>None</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Velma McGhee</u>		Address <u>Woodriver, Illinois</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MENINGITIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
DUE TO (b) <u>CHRONIC OTITIS MEDIA WITH MASTOIDITIS AND EPIDURAL ABSCESS</u>										19-20 YRS.			
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 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 <u>JULY 20, 1959</u> to <u>JULY 21, 1959</u> and last saw her/him alive on <u>JULY 21, 1959</u> Death occurred at <u>3:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title) <u>M. D.</u>						22b. ADDRESS <u>BARNES HOSPITAL</u>				22c. DATE SIGNED <u>7/22/59</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-22-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>		23d. LOCATION (City, town, or county) <u>Edwardsville, Illinois</u>							
24. FUNERAL DIRECTOR <u>Marks Funeral Home Woodriver, Illinois</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>JUL 22 '59</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>mjb</u>							

DOCUMENT
B a.k. Paul J. ...
Deputy Coroner
7/23/59

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 Lawrence O. Seeling

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo.

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.