

IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-027141

FILED VS AUG 5 1959

2 6845

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's _____

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 <u>ST. LOUIS</u>		a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>	
Length of stay in 1b <u>15 DAYS</u>		c. CITY OR TOWN <u>GRANITE CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>2733 SUNSET DRIVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARtha</u> Middle <u>—</u> Ruffer		4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1876</u>
9. AGE (last birthday) <u>82</u>		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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>CRYSTAL CITY, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>THOMAS SMITH</u>	

13b. MOTHER'S MAIDEN NAME <u>ELIZABETH PASS</u>		14. NAME OF HUSBAND OR WIFE <u>—</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>Ray Ruffer</u>		Address <u>Granite City, Mo.</u>	

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 <u>2 Wks</u> <u>7 mos</u>
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		
DUE TO (b) <u>Chronic Int Nephritis</u>		
DUE TO (c) <u>—</u>		

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 Dec 15 1956 to 7-21-59 and last saw her alive on 7-20-59
Death occurred at 7:50 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Noting Haxer M.D.</u> (Doctor or title)	22b. ADDRESS <u>526 Olive St</u>	22c. DATE SIGNED <u>7-22-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET HILL</u>
23d. LOCATION (City, town, or county) (State) <u>EDWARDSVILLE - ILL.</u>		

24. FUNERAL DIRECTOR <u>DAVID G. HODGE</u>	ADDRESS <u>2118 State St Granite City, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 23 '59</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>
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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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

David G. Adye

Licensed Embalmer No. 4900

P. O. Address 2118 State
Granite Ci

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.