

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-030478

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7689** STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI			Length of stay in 1b 14da		c. CITY OR TOWN Madison		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1902 Fifth St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ARTHUR Middle C. Last HEISTAND			4. DATE OF DEATH Month AUGUST Day 16 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24-1886	9. AGE (last birthday) 72	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) Retired			10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (City and state or country) Salem, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Columbus Heistand			13b. MOTHER'S MAIDEN NAME Florence Emil			14. NAME OF HUSBAND OR WIFE Rosa Heistand		
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. 333-08-6264		17. INFORMANT A dress Rosa Heistand Madison, Ill.			
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) PULMONARY CONGESTION AND PLEURAL EFFUSION							FEW DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) SEPTICEMIA, SUSPECTED, AND GASTROINTESTINAL BLEEDING						2 WEEKS	
	DUE TO (c) FOCAL MEMBRANOUS ULCERATIVE COLITIS						2 WEEKS	
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 AUGUST 2, 1959 to AUGUST 16, 1959 and last saw her alive on AUGUST 16, 1959 Death occurred at 1:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>R. Bradley</i>			(Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 8/17/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-19-1959	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) Granite City, Ill.			(State)	
24. FUNERAL DIRECTOR John L. Sedlack Madison, Ill.			ADDRESS		25. DATE RECD. BY LOCAL REG. AUG 18 '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 ^{not} embalmed by me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John T. Leeseck

Licensed Embalmer No. 3747

P. O. Address Madison,

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.