

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 27 1959

2 7587

59-030596

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

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>Greene</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb _____		c. CITY OR TOWN <u>White Hall</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. Luke's Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>323 West Bridgeport</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>Elizabeth</u> Last <u>McClure</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/16/1907</u>		9. AGE (last birthday) <u>51</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>White Hall, Illinois.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Robert Livingstone</u>				13b. MOTHER'S MAIDEN NAME <u>Lida Smith</u>				14. NAME OF HUSBAND OR WIFE <u>Stanley McClure</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Nil</u>			17. INFORMANT <u>Stanley McClure, 323 West Bridgeport,</u>			Address <u>White Hall, Illinois.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MEDULLARY COMPRESSION, POST. OPERATIVE.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>MEGALOBLASTIC ANEMIA, RT. POSTERIOR CROSSA</u>										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 checked="" 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>Aug 10</u> to <u>Aug 13</u> and last saw her/him alive on <u>Aug 13</u> Death occurred at <u>10:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>George J. Hawkswain, M.D.</u> (Degree or title)								22b. ADDRESS <u>3720 Washington Blvd.</u>		22c. DATE SIGNED <u>8/12/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>8-16-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>			23d. LOCATION (City, town, or county) <u>White Hall, Illinois.</u>					
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u> ADDRESS _____					25. DATE RECD. BY LOCAL REG. <u>AUG 15 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>						

DOCUMENT

MEDICAL CERTIFICATION

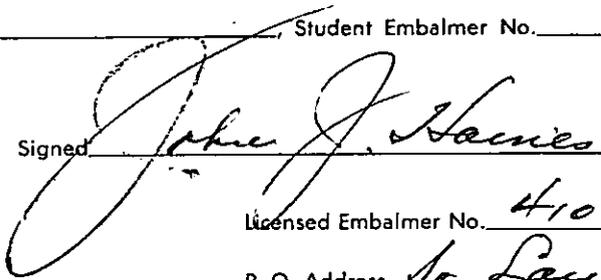
BY AFFIDAVIT OF

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 _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4108

P. O. Address St 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.