

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034016

FILED VS. OCT. 8, 1959

STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 8281**

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| 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 ST. LOUIS | | Length of stay in lb | c. CITY OR TOWN SMITHTON |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSP | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) SMITHTON |

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|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First JOHN Middle _____ Last LANG | | | 4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1959 | |
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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|--|
| 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 1-31-1926 | 9. AGE (last birthday) 33 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____ |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING | 10b. KIND OF BUSINESS OR INDUSTRY OWN FARM | 11. BIRTHPLACE (City and state or country) ILLINOIS | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME JOHN LANG, SR | 13b. MOTHER'S MAIDEN NAME MARY ROOS | 14. NAME OF HUSBAND OR WIFE VIOLET (Schrauth) MEE |
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|---|---|-------------------------------------|----------------------------------|
| 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. UNKNOWN | 17. INFORMANT VIOLET LANG | Address SMITHTON, ILL. |
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| 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) | HODGKIN'S DISEASE | 1-2 YEARS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | 201x |

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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 type="checkbox"/> Yes <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year |
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| | | | | |
|--|--|------------------------------|--------|-------|
| 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 **SEPT. 1, 1959** to **SEPT. 7, 1959** and last saw her/him alive on **SEPT. 7, 1959**
Death occurred at **11:50 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Carl Van Allen M.D.</i> | (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 9/8/59 |
|--|-----------------------------------|--|-----------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE SEPT. 10 1959 | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN BAPTIST SMITHTON ILL. | 23d. LOCATION (City, town, or county) (State) ILL. |
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| 24. FUNERAL DIRECTOR George Bremer & Sons Belleville, Ill. | 25. DATE RECD. BY LOCAL REG. SEP 8'59 | 26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> |
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(Licensed Embalmer's Statement on Reverse Side)

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 not embalmed, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George M. Berman

Licensed Embalmer No. 5051

P. O. Address Bellville

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.