...OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-034042
STATE FILE NUMBER

...MENDED FILED VS OCT 8 1959 Registrar's District No. _____ Primary Registration District No. _____ Registrar's No. 2-8318

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 — Length of stay in 1b: 6 days	c. CITY OR TOWN Venice Township — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) 209 Hair Street — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: JOHN	Middle	Last: LOUIE	4. DATE OF DEATH	Month: Sept	Day: 6,	Year: 1959
5. SEX: Male	6. COLOR OR RACE: Negro	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐		8. DATE OF BIRTH: Aug 15, 1902	9. AGE (last birthday): 57	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): Unemployed laborer	10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (City and state or country): Howard, Mississippi		12. CITIZEN OF WHAT COUNTRY: USA			
13a. FATHER'S NAME: Major Louie	13b. MOTHER'S MAIDEN NAME: Susie Burl			14. NAME OF HUSBAND OR WIFE: Marie Louie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: Marie Louie	Address: 209 Hair St., Venice Twp, Ill				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) left bronchogenic Ca — Left Bronchogenic Cancer

DUE TO (b) Carcinoma of left lung — Carcinoma of the Lung

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (c) 162.1

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 7-10-59 to 9/6/59 and last saw her/him alive on 9/6/59

Death occurred at 4 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Edgar F. Wordsworth M.D.	(Degree or title)	22b. ADDRESS: 930 N 2ND St. Louis Ill	22c. DATE SIGNED: 9/8/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 9/9/59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State): East St. Louis, Illinois
24. FUNERAL DIRECTOR: Marshall Funeral Home	ADDRESS: E.St.Louis, Ill.	25. DATE RECD. BY LOCAL REG.: SEP 9 '59	26. REGISTRAR'S SIGNATURE: Noel Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Thomas M Klobe

Signature of Student Embalmer

Licensed Embalmer No. 4479

P. O. Address East St. Louis, Il

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.