

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 29 1959

59-034523

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar **2 8410**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY Cass	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b 5 days	c. CITY OR TOWN Ashland	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Childrens	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Jean Middle Ella Last Yancy			4. DATE OF DEATH Month September Day 10 , Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-13-54	9. AGE (last birthday) 4 yrs	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Springfield, Ill	12. CITIZEN OF WHAT COUNTRY U.S. A.	
13a. FATHER'S NAME Albert Henry Yancy		13b. MOTHER'S MAIDEN NAME Lois Petefish		14. NAME OF HUSBAND OR WIFE never married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N of service		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Jane Henrichsen-500 S, Kingshighway		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation		INTERVAL BETWEEN ONSET AND DEATH 15 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congenital Heart Disease - Cong. Valvular Disease of Aortic and Mitral Valves.	4 years
	DUE TO (c) Coronary Arteriosclerosis - Mitral Insufficiency	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post op - Open Heart Surgery		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 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 Ashland, Illinois	COUNTY _____ STATE _____
21. I attended the deceased from 9-5-59 to 9-10-59 and last saw her alive on 9-10-59 Death occurred at 10:43 am on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE Lebfiard B. Rome (Degree or title) M.D. Leonard Peter Rome M.D.	22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 9-10-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-11-59	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Ashland, Illinois.

24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. SEP 11 '59	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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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

Oliver R. Sadwell

Licensed Embalmer No. 4077

P. O. Address St Louis

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.

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