

PURVIS DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037471

FILED VS OCT 23 1959

2 9374

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MONTGOMERY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Length of stay in lb 46 DAYS	c. CITY OR TOWN LITCHFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE #3 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First **JAMES** Middle **A.** Last **CARROLL** 4. DATE OF DEATH Month **OCTOBER** Day **10** Year **1959**

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/20/19	9. AGE (last birthday) 40	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) GILLESPIE, ILLINOIS	12. CITIZEN OF WHAT COUNTRY USA
--	--	---	--

13a. FATHER'S NAME JOHN CARROLL	13b. MOTHER'S MAIDEN NAME MARY ELLEN WILLIAMSON	14. NAME OF HUSBAND OR WIFE -----
--	--	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 328-22-6006	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS MO.
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ORTHOSTATIC PNEUMONIA**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **CARCINOMATOSIS**

DUE TO (c) **199.2**

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 <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 _____ Month, Day, Year _____ p.m.

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. VA attended the deceased from **8/25/59** to **10/10/59** and last saw him alive on **10/10/59**
Death occurred at **2:45 PM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) Sam E. Mowik, Jr.	22b. ADDRESS M.D. VAH, ST LOUIS MO	22c. DATE SIGNED 10-11-59 (State)
---	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/12/59	23c. NAME OF CEMETERY OR CREMATORY Raymond, Illinois	23d. LOCATION (City, town, or county) (State)
--	---------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Robert A. Hough Raymond, Ill.	25. DATE RECD. BY LOCAL REG. OCT 13 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
---	--	---

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 Not Embalmed
Signature of Student Embalmer

Signed Joseph J. Keady

Licensed Embalmer No. 7541

P. O. Address E. 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.