

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 3 1959

59-037641

2 9756

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 Richland				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN Olney		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 201 N. Boone		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gary Middle W. Last Gray				4. DATE OF DEATH Month October Day 21 Year 1959				
5. SEX Male	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 6/12/1959	9. AGE (last birthday) 4	IF UNDER 1 YEAR Months 4 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) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Olney, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Robert Gray			13b. MOTHER'S MAIDEN NAME Veda Jones			14. NAME OF HUSBAND OR WIFE None		
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. None		17. INFORMANT Robert Gray, Olney, Ill. Address _____			
18. CAUSE OF DEATH (Enter only the cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral subdural hematomas DUE TO (b) Fall on the head. DUE TO (c) Post op. hemorrhage stroke							INTERVAL BETWEEN ONSET AND DEATH 1 week abt. 7 1/2 h	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease conditions 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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Child was accidentally dropped on the head by parent				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 10-13-59		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.) Home			20f. CITY, TOWN, OR LOCATION Olney, Ill. Richl.					
21. I attended the deceased from 10-15-59 to 10-21-59 and last saw him ^{keep} alive on 2:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Jacques C. Wheeler, M.D.				22b. ADDRESS 6500 Arpway			22c. DATE SIGNED 23 Oct 59	
23a. BURIAL CREATION, REMOVAL (Specify) Removal		23b. DATE 10-24-59	23c. NAME OF CEMETERY OR CREMATORY Hankins Cemetery		23d. LOCATION (City, town, or county) Olney, Ill.		(State)	
24. FUNERAL DIRECTOR Parker-Flagg Funeral Home, Newton, Ill. ADDRESS _____				25. DATE RECD. BY LOCAL REG. OCT 24 1959		26. REGISTRAR'S SIGNATURE Coal Smith, M.D. H.T.		

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 _____
No Embalmed
H. H. H. H.
Licensed Embalmer No. _____
P. O. Address _____

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.