

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038543

FILED VS NOV 16 1959

Registration District No. 317 Primary Registration District No. 590 500 Registrar's No. 2996 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>S t. Louis,</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u>		Length of stay in 1b <u>5 yrs. 5 mos.</u>		c. CITY OR TOWN <u>Rock Island</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>815 24th Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>REVEREND SEVERIUS</u> Middle <u>VAN DER GULIK</u> Last				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/81</u>		9. AGE (last birthday) <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Priest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (City and state or country) <u>Bovenkarspel, Holland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		IF UNDER 1 YEAR Months <u>6</u> Days	
13a. FATHER'S NAME <u>Anthony Van Der Gulik</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Schaper</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT Address <u>Records of Chancery Office 607 North Madison Avenue, Peoria, Ill.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Bronchial Pneumonia Right</u> DUE TO (b) <u>Old Cardiovascular Renal disease</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis Generalized Osteoarthritis</u>						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 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 <u>12:45</u> 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		COUNTY		STATE	
21. I attended the deceased from <u>6-4-54</u> , to _____ and last saw <sup>him</sup> live on <u>11-11-59</u> Death occurred at <u>12:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>F.E. Kesteloch M.D.</u>				22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>				22c. DATE SIGNED <u>11/11/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 12, 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>E. Moline Ill.</u>			
24. FUNERAL DIRECTOR <u>Cullen Kelly</u>			ADDRESS <u>7267 Natural Bridge</u>		25. DATE RECD. BY LOCAL REG. <u>11-12-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 11 1962

**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 James A. Lamm

Licensed Embalmer No. 4142

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.