

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042313

FILED VS. NOV 20 1959

210462

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>16 days</b>	c. CITY OR TOWN <b>Maryville</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cardinal Glennon Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>none</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED <b>Paul</b> First Middle <b>Michael</b> Last <b>Oberkfell</b> (Type or print) <b>Paul Michael Oberkfell</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>13</b> Year <b>'59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-19-1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (last birthday) <b>1</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) <b>Granite City, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Harold L. Oberkfell</b>		13b. MOTHER'S MAIDEN NAME <b>Alma Ruth Johnson</b>	
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) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Harold L. Oberkfell</b> Address <b>Maryville, Ill.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia - bilateral pneumonia due to</b> DUE TO (b) <b>internal hydrocephalus due to Tuberculosis</b> DUE TO (c) <b>meningitis secondary to primary tuberculosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH But not related to the terminal disease condition given in PART I (a) <b>Hydrocephalus caused coma - secondary pulmonary complications</b>			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.) <b>No injury 019.2</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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. I attended the deceased from <b>30 Oct 59</b> to <b>13 Nov 59</b> and last saw him alive on <b>13 Nov 59</b> Death occurred at <b>2:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. H. Smith, M.D.</b> (Degree or title)		22b. ADDRESS <b>Cardinal Glennon Hosp</b>	22c. DATE SIGNED <b>13 Nov 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-15-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairland</b>	23d. LOCATION (City, town, or county) (State) <b>Maryville, Illinois</b>
24. FUNERAL DIRECTOR <b>Herbert A. Kassly</b> ADDRESS <b>Collinsville, Illinois</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 13 1959</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b> <i>ms</i>

(Licensed Embalmer's Statement on Reverse Side)

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]*  
Signature of Student Embalmer

Signed *[Signature]*

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.