

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 8 8

FILED TO DEC 21 1959

Registration District No. 1000 Primary Registration District No. 211193 REGISTRAR'S STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Maryville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>HENRY</u> Last <u>LUCAS</u>			4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-99</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>		11. BIRTHPLACE (City and state or country) <u>Maryville, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Tony Lucas</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Wansing</u>		14. NAME OF HUSBAND OR WIFE <u>Antoinette Polic</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>344-14-7567</u>		17. INFORMANT Address <u>Antoinette Lucas, Maryville, 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) Subdural Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Multiple contusions through out the body.

DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suffered in auto accident in the city of Granite City, Ill., on or about Nov 29, 1959

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  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, extent, nature of injury to PART I of PART II of item 18.) <u>Verdict Ill., on or about Nov 29, 1959</u>
20c. TIME OF INJURY Hour <u>11:29</u> a.m. <u>59</u> p.m. <u>11:29</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>7th St. Maryville</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Granite City Ill</u>	

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at 445A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edmund E. Kasper</u> (Degree or title)	22b. ADDRESS <u>1300 Chasen</u>	22c. DATE SIGNED <u>12/3/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/3/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge Lutheran Collinsville Township, Ill</u>
24. FUNERAL DIRECTOR ADDRESS <u>Edmund E. Kasper Collinsville, Ill.</u>		23d. LOCATION (City, town, or county)

25. DATE RECD. BY LOCAL REG. <u>DEC 3 1959</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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  
or by Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Peabody H. Kelly

Licensed Embalmer No. 2803

P. O. Address Collinsville

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.