

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 15 1960

'59 0 4 5 6 9 6

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

211945

ENDED

| | | | | | |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Randolph | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis. | | Length of stay in 1b 16 1/2 hrs. | | c. CITY OR TOWN Chester | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's* | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS Route #1 | |
| | | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) Paul Leland McCree | | | 4. DATE OF DEATH Month 12 Day 24 Year 59 | | |
| 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 7/1/59 | 9. AGE (last birthday) 5 months 56 | IF UNDER 1 YEAR Months 5 Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and state or country) Chester Illinois | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME William Arthur McCree | | 13b. MOTHER'S MAIDEN NAME Barbara 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) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT J. Donahoe | | Address 500 S. Kingshighway | | | |

| | | | |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac arrest | | | |
| DUE TO (b) Cardiac failure - acute | | | |
| DUE TO (c) Endocardial fibrosclerosis | | | 16 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) a. Separation of the aorta - repaired & b. Bronchopneumonia | | | 4 mmr |
| 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 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 **Dec. 23 1959** to **Dec. 24 59** and last saw him alive on **Dec. 24 1959**
Death occurred at **9:00 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|---|------------------------------|---|---|--|
| 22a. SIGNATURE Frederick D. Peterson MD | | 22b. ADDRESS 500 So. Kingshighway | | 22c. DATE SIGNED 12-24-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-27-59 | 23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery | 23d. LOCATION (City, town, or county) Walsh, Illinois | |
| 24. FUNERAL DIRECTOR John J. Kessler | | ADDRESS E. St. Louis, Illinois | | 25. DATE RECD. BY LOCAL REG. DEC 24 1959 |
| | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | |

ent here from 9/22/59 to 10/23/59 (licensed Embalmer's Statement on Reverse Side) Re-admitted 12/23/59

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Kaschig III

Licensed Embalmer No. 11119

P. O. Address 11119

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.