

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 8 1960

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211647

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 <b>ST. CLAIR</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>10 DAYS</b>		c. CITY OR TOWN <b>East St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <b>St. Louis-Little Rock Hosp., Inc.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RR #2 Box 55 Church Lane</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>O'Connell</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-20-1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pensr. Switchman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>MINNEAPOLIS MINN.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>WILLIAM D O'CONNELL</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</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>702-12-3509</b>		17. INFORMANT <b>Mrs Charles Margeson RR2 Church Lane</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>Chronic Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Senility</b> <b>4200</b>							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)						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 _____ 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 <b>Dec. 5, 1959</b> to <b>Dec. 15, 1959</b> and last saw him alive on <b>Dec. 14, 1959</b>				Death occurred at <b>1:12 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ann Bayl M.D.</b>			22b. ADDRESS <b>12-15-59 1755 S. Grand Blvd.</b>			22c. DATE SIGNED <b>12/15/59</b> (State) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL</b>		23d. LOCATION (City, town, or county) <b>Belleveville Ill.</b>		
24. FUNERAL DIRECTOR <b>Nell-Walsh-Barnes, Funeral Home</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 16 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

E. St. Louis, Ill.

(Licensed Embalmer's Statement on Reverse Side)

**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 Maher  
Licensed Embalmer No. 29-82

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.