

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JAN 22 1960

-60-003628
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>Jersey</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in lb <u>182 DAYS</u>	c. CITY OR TOWN <u>JERSEYVILLE</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>VAH, 915 NO. GRAND AVE.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>108 HOLLOW</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD L. KADELL</u>			4. DATE OF DEATH Month Day Year <u>1-12-60</u>		
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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>4/7/25</u>	9. AGE (last birthday) <u>34</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (City and state or country) <u>JERSEYVILLE, ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>WILLIAM KADELL</u>	13b. MOTHER'S MAIDEN NAME <u>FRANCES KADELL</u>	14. NAME OF HUSBAND OR WIFE <u>MILDRED KADELL</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW-II</u>	16. SOCIAL SECURITY NO. <u>352-20-7797</u>	17. INFORMANT <u>MILDRED KADELL (WIDOW)</u> Address <u>108 HOLLOW JERSEYVILLE, ILL.</u>
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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 <u>9 MONTHS</u>
IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA TO RIGHT ILLIUM; LIVER; BRAIN</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>BRONCHOGENIC CARCINOMA LEFT LUNG</u>	
	DUE TO (c) <u>POST - PNEUMONECTONY</u>	

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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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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
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21. <u>VA</u> attended the deceased from <u>7/14/59</u> to <u>1/12/60</u> and last saw <u>him</u> alive on <u>1/12/60</u> Death occurred at <u>8:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>William L. Goettman</u> (Degree or title) <u>WILLIAM L. GOETTMAN</u> M.D.	22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>1/12/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jerseyville</u>	23d. LOCATION (City, town, or county) (State) <u>ILLINOIS</u>
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24. FUNERAL DIRECTOR <u>JACOBY BROS.</u>	ADDRESS <u>Jerseyville, ILL</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 12 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb.

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

Frank Prosoff

Licensed Embalmer No.

4356

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.