

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004067

FILED VS JAN 29 1960

Registration District No.

Primary Registration District No.

Registrar's

2

616

STATE FILE NUMBER

INDEXED

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> COUNTY <u>FRANKLIN</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Length of stay in 1b <u>7 Days</u>		c. CITY OR TOWN <u>ORIENT</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>FIRMIN Desloge</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>GENERAL DELIVERY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>KASTOS</u> Middle <u>SIMKUNAS</u> Last <u>SIMKUNAS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>60</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>6-24-1889</u>		9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COAL</u>		11. BIRTHPLACE (City and state or country) <u>LITHUNIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				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) <u>No</u>				16. SOCIAL SECURITY NO. <u>522-12-9636</u>		17. INFORMANT <u>John Simkunas</u>		Address <u>Orient, Ill</u>					
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) <u>AORTIC INSUFFICIENCY</u>										<u>7 years</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>RHEUMATIC HEART DISEASE</u>										<u>7 years</u>			
DUE TO (c) <u>411 X</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>OLD PULMONARY INFARCTION,</u>								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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> / <u> </u> / <u> </u>													
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 <u>JAN. 11, 1960</u> to <u>JAN. 18, 1960</u> and last saw ^{her} him alive on <u>JAN. 17, 1960</u> Death occurred at <u>5</u> <u>A.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Herbert C. Sweet M.D.</u>						22b. ADDRESS <u>508 N. Grand</u>			22c. DATE SIGNED <u>1-18-60</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>1-19-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DENNING CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>WEST FRANKFORT ILL.</u>							
24. FUNERAL DIRECTOR <u>UNION</u>				ADDRESS <u>West Frankfort</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 19 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>M. J. B.</u>					

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 Frank Prohoff

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 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.