

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004276

FILED VS FEB 11 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1132** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u> East <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>17 days</u>		c. CITY OR TOWN <u>East St. Louis</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>Lutheran Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>726 North 28th Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Elizabeth Zelay.</u>				4. DATE OF DEATH Month Day Year <u>Jan. 30th 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/23/1886</u>			
9. AGE (last birthday) <u>73</u>		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) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (City and state or country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Alex Forhetz</u>			13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>Stephen Zelay</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>None.</u>				17. INFORMANT <u>Steve Zelay 557 North 27th St.</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) <u>METASTATIC CARCINOMA TO BRAIN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 MO</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA RIGHT MAXILLARY SINUS</u>							<u>ABOUT 6 MO</u>		
DUE TO (c) <u>160-2</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
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 <u>1/13/60</u> to <u>1/30/60</u> and last saw her/him alive on <u>1/30/60</u> Death occurred at <u>1:42 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>George A. Lawson M.D.</u>				22b. ADDRESS <u>5203 Chippewa Ave</u>				22c. DATE SIGNED <u>2/1/60</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>2/2/1960</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemty.</u>		23d. LOCATION (City, town, or county) <u>Belleville Illinois</u>		(State)	
24. FUNERAL DIRECTOR <u>Geo Bruehler Jr.</u>				25. DATE RECD. BY LOCAL REG. <u>FEB 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</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 Eugene Chaplain

Licensed Embalmer No. 5003
203 So. Second
P. O. Address Quincy, Ill.

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.