

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS MAR 28 1960

60-012893
 STATE FILE NUMBER

2 3026

NDED

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 13 days	c. CITY OR TOWN Alorton, Illinois East St. Louis Carleean Township
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 300 South 50th. Str.,

3. NAME OF DECEASED (Type or print) First Daniel Middle Albert Last Louby			4. DATE OF DEATH Month March Day 14, Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad (A&S)	11. BIRTHPLACE (City and state or country) Juka, Illinois	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Timothy Louby		13b. MOTHER'S MAIDEN NAME Alice Hall		14. NAME OF DECEASED'S WIFE Philisity Louby	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 702-09-1887	17. INFORMANT Mrs. Phlisity Louby 300 South 50th St Alorton, Ill.
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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
IMMEDIATE CAUSE (a) Carcinomatosis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of the left kidney	1 yr
	DUE TO (c) 180x	

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.)	
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 Xenia, Ill.	STATE
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21. I attended the deceased from **March 2, 1960** to **March 14, 1960** and last saw ~~him~~ ^{her} live on **Mrch 14, 1960**
 Death occurred at **7:35 p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul J. Gasto M.D. (Degree or title)	22b. ADDRESS 1755 So Grand	22c. DATE SIGNED 3/15/60 (State)
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22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE Mar. 17, 1960	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Centy	23d. LOCATION (City, town, or county) Xenia, Ill.
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24. FUNERAL DIRECTOR Brichler Funeral Home - 2216 State Str.	ADDRESS East St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. MAR 15 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed
W. Bricker

Licensed Embalmer No. _____

P. O. Address _____

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.