

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 4 1960

60-012956

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3443** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN Williamsville	
Length of stay in lb 1day		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Childrens''		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Dana Middle Robert Last Messersmith			4. DATE OF DEATH Month 3 Day 24 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/23/60	9. AGE (last birthday) 1day	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) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Springfield, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Robert Messersmith		13b. MOTHER'S MAIDEN NAME Marilyn Cooper		14. NAME OF HUSBAND OR WIFE None		
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. None		17. INFORMANT Address AnnaMarie Larson 500 S. Kingshighway		

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) Bilateral Bunchy pneumonia (Non-specific)		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Post-op Teacher-Emphyseal Fistula	
	DUE TO (c) Prematurity 756.2	
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 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	COUNTY STATE
21. I attended the deceased from 3/23/60 to 3/24/60 and last saw her ^{her} him alive on 3/24/60 Death occurred at 6:55 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leonard Peter Rome M.D.		22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 3-25-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-26-60	23c. NAME OF CEMETERY OR CREMATORY Walnut Hill Cemetery	23d. LOCATION (City, town, or county) (State) Williams Township, Ill.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Bld.		25. DATE RECD. BY LOCAL REG. MAR 26 1960	26. REGISTRAR'S SIGNATURE Roan Smith M.D.

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

John J. Haines

Licensed Embalmer No. 4108

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).

e - 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.