

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 17 1960

60-013052

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2652** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>Madison</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Louis Little Rock Hosp Inc</b>				d. STREET ADDRESS (If outside, give location) <b>1669 2nd St</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Nicholas</b> Last <b>Park</b>				4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> , Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> , Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1,8,79</b>	9. AGE (last birthday) <b>81</b>	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) <b>General Yard Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Knightsville, Ind.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Alexander Park</b>			13b. MOTHER'S MAIDEN NAME <b>Rebecca Snell</b>		14. NAME OF HUSBAND OR WIFE <b>Amy Scofield Park</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>702,09,2529</b>		17. INFORMANT Address <b>Mrs. Amy Park 1669 2nd St., Madison, Ill.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>420.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Nephrosclerosis---Chololithiosis</b>						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 <b>9.10</b> a.m. p.m.		Month, Day, Year <b>Jan. 27, 1960</b>		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 <b>March 5, 1960</b>		COUNTY		STATE	
21. I attended the deceased from <b>Jan. 27, 1960</b> to <b>March 5, 1960</b> and last saw her alive on <b>3,5,60</b> Death occurred at <b>9.10 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Amey Scofield</i> (Degree or title)				22b. ADDRESS <b>1755 So Grand</b>		22c. DATE SIGNED <b>3-6-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-9-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cottage Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brazil, Indiana</b>	
24. FUNERAL DIRECTOR <b>Kurrus Funeral Home</b>		ADDRESS <b>E. St. Louis, Ill.</b>		25. DATE RECD. BY LOCAL REG <b>MAR 7 1960</b>		26. REGULAR'S SIGNATURE <i>Carl Smith. M.D.</i>	

(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

**NOT EMBALMED**  
Signed *Kurru J. Jorgensen*  
J. R. Jorgensen  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.