

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 13 1960

318

1003

4671

-60-016847

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>St Louis</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Illinois</i> b. COUNTY <i>Perry</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i> | | Length of stay in lb <i>90 Days</i> | c. CITY OR TOWN <i>Pinckneyville</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Deaconess Hosp.</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>915 County Road</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|--|--|
| 3. NAME OF DECEASED (Type or print) First <i>Mrs. Hazel</i> Middle <i>L.</i> Last <i>Gilley</i> | 4. DATE OF DEATH Month <i>5</i> Day <i>2</i> Year <i>60</i> |
|--|--|

| | | | | | | |
|----------------------|-------------------------------|---|------------------------------------|----------------------------------|--------------------------------|------------------------------|
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-28-1914</i> | 9. AGE (last birthday) <i>45</i> | 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) <i>Housewife</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | 11. BIRTHPLACE (City and state or country) <i>Coulterville, Ill</i> | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i> |
|--|--|---|--|

| | | |
|--|--|--|
| 13a. FATHER'S NAME <i>MAURICE A. BOVAS</i> | 13b. MOTHER'S MAIDEN NAME <i>INA MILES</i> | 14. NAME OF HUSBAND OR WIFE <i>SPENCER</i> |
|--|--|--|

| | | |
|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | 16. SOCIAL SECURITY NO. <i>337-18-0177</i> | 17. INFORMANT <i>Spencer Gilley</i> Address <i>Pinckneyville Ill</i> |
|--|--|--|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal carcinomatous.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>6/24/57-60</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>AdenoCarcinoma of retroigmoid.</i> | |
| | DUE TO (c) <i>154x</i> | |

| | |
|---|---|
| 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 <i>5:25</i> a.m. p.m. | Month, Day, Year <i>6-10-58</i> |
|---|---------------------------------|

| | | |
|---|--|---|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 *6-10-58* to *5-2-60* and last saw ^{her} alive on *5/2/60*
Death occurred at *5:25 PM* on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---|--------------------------------|
| 22a. SIGNATURE (Degree or title) <i>James Y. Trigg M.D.</i> | 22b. ADDRESS <i>7820 Carondelet Clayton</i> | 22c. DATE SIGNED <i>5/3/60</i> |
|---|---|--------------------------------|

| | | | |
|--|-------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | 23b. DATE <i>5-3-60</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Coulterville Cem</i> | 23d. LOCATION (City, town, or county) <i>Coulterville Illinois</i> |
|--|-------------------------|--|--|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR <i>Pyatt</i> ADDRESS <i>Pinckneyville Ill</i> | 25. DATE RECD. BY LOCAL REG. <i>MAY 3 1960</i> | 26. REGISTRAR'S SIGNATURE <i>Joan Smith, M.D.</i> |
|--|--|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m/b

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 Proff

Licensed Embalmer No. 4356

P. O. Address St. Louis

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.