

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021063

FILED VS JUN 6 1960

318

1003

5322

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

INDEXED

| | | | | | | | | | |
|---|--|---|---|--|--|--|---|------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> | | Length of stay in 1b <u>10 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>BARNES HOSPITAL</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>1469 Missouri Ave</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>NMN</u> Last <u>HOARD</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1960</u> | | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/29/1901</u> | 9. AGE (last birthday) <u>58 yrs</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>Retired Laborer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Packing Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>East St. Louis, Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | |
| 13a. FATHER'S NAME <u>Richard Hoard</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Weaver</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Jessie Hoard</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no/unknown) (If yes, give war or dates of service) <u>Yes World War I</u> | | | 16. SOCIAL SECURITY NO. <u>327-03-3577</u> | | 17. INFORMANT Address <u>Jessie Hoard-1469 Missouri, E. St. Louis, Ill.</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>RIGHT INTERNAL CAROTID ARTERY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>332X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>YEARS</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHOPNEUMONIA</u> | | | | | 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 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>MAY 9, 1960</u> to <u>MAY 19, 1960</u> and last saw her/him alive on <u>MAY 19, 1960</u> Death occurred at <u>12:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>C. D. Vamellia, M.D.</u> | | | | 22b. ADDRESS <u>BARNES HOSPITAL</u> | | | | 22c. DATE SIGNED <u>5/19/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>5/23/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National</u> | | | 23d. LOCATION (City, town, or county) <u>Jefferson Barracks, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Marshall Funeral Home-E. St. Louis, Ill.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>MAY 20 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

219B

RECEIVED BY MAIL

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 Thomas M. Roberts

Licensed Embalmer No. 4479

P. O. Address 2205 Missouri A
East St. Louis

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.