

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021666

FILED VS MAY 25 1960

318

Primary Registration District No. 1003

Registrar's No. 5253

STATE FILE NUMBER

INDEXED

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>8 days</i>	c. CITY OR TOWN <i>Mount Vernon</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>St. Louis Children's</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>715 S. 18th St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Deana Jean Watson</i>			4. DATE OF DEATH Month Day Year <i>5 18 60</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>4-4-60</i>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (City and state or country) <i>Mount Vernon, Ill</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>William D. Watson</i>		13b. MOTHER'S MAIDEN NAME <i>Phillis Caron</i>		14. NAME OF HUSBAND OR WIFE <i>none</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>none</i>		17. INFORMANT Address <i>Anne Dudley 500 S. Kingshighway</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>Cardiac arrest</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Coronary heart disease - pulmonary</i>	
	DUE TO (c) <i>chronic and later trial renal defect</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>754.3</i>		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.) <i>754.3</i>
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 <i>5-10-60</i> to <i>5-18-60</i> and last saw her/him alive on <i>5-18-60</i> Death occurred at <i>8:40</i> <i>A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>Embalmers J Peterson MD</i>	22b. ADDRESS <i>500 S. Kingshighway</i>	22c. DATE SIGNED <i>5-18-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>5-19-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LAKE View Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Johnston City Illinois</i>
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24. FUNERAL DIRECTOR ADDRESS <i>MURMAN & Wilson Johnston City</i>	25. DATE RECD. BY LOCAL REG. <i>MAY 19 1960</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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ILL (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 Frank Proloff

Licensed Embalmer No. 4356

P. O. Address St Louis 7

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.