

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 7 1960

-60-025298
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1959

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		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 or HTYS.) <u>ORCHARD HTYS.</u> OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>EAST ST LOUIS</u>	
Length of stay in 1b <u>1 1/2 Days</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARY'S HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>8628 BOTANICAL</u>	
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 <u>ORVILLE</u> Middle <u>EDGAR</u> Last <u>WICKS</u>			4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>3-12-1907</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAND PLASTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL Co.</u>	11. BIRTHPLACE (City and state or country) <u>E. St. Louis ILL.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JAMES WICKS</u>	13b. MOTHER'S MAIDEN NAME <u>ELLA Bequette</u>	14. NAME OF HUSBAND OR WIFE <u>Dorothy</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>355-01-2934</u>	17. INFORMANT <u>Dorothy Wicks E. St. Louis Ill.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Rupture of Aneurysm Rt. Middle Cerebral</u> <u>c. Intracerebral Hematoma</u>		

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	
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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 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 6-24-60 to 6-25-60 and last saw her/him alive on 6-25-60
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank A. Palazzo</u> (Degree or title)	22b. ADDRESS <u>4161 Lindell, St. Louis, Mo.</u>	22c. DATE SIGNED <u>6-27-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-27-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>CANTOEN TOWNSHIP ST. CLAIR Co. ILLINOIS</u>
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24. FUNERAL DIRECTOR <u>Robins</u>	ADDRESS <u>E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>6-27-60</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 Aspen

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.