

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028252

FILED VS JUL 22 1960

318

1003

7003

STATE FILE NUMBER

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

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | a. STATE Illinois | b. COUNTY Macon |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | c. CITY OR TOWN Decatur | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 328 So. Wyckels | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First VIRGINIA | Middle C. | Last DICK | Month JULY | Day 11 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/21/1931 | 9. AGE (last birthday) 28 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Glasco, Kentucky. | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Urey Glass | | 13b. MOTHER'S MAIDEN NAME Unavailable | | 14. NAME OF HUSBAND OR WIFE John Dick | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil | | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT John Dick, Decatur, Illinois. | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) ASPIRATION | | 5 MINUTES |
| DUE TO (b) ACUTE INCREASED INTRACRANIAL PRESSURE | | 4 DAYS |
| DUE TO (c) CRANIOPHARYNGIOMA 224x | | 8 YEARS |
| 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 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 _____ a.m. _____ p.m. _____ | Month, Day, Year | |
| 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 **APRIL 30, 1960** to **JULY 11, 1960** and last saw her **him** alive on **JULY 11, 1960**
 Death occurred at **7:58 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--|-----------------------------------|--|--|
| 22a. SIGNATURE <i>C. D. Venilla, M.D.</i> | (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 7/12/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7/11/60 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) (State) Decatur, Illinois. |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd., | ADDRESS | 25. DATE RECD. BY LOCAL REG. JUL 12 1960 | 26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 _____

Licensed Embalmer No. 4108

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.