

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028352

FILED VS AUG 8 1960

318 Primary Registration District No. **1003**

7364

STATE FILE NUMBER

INDEXED

| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Franklin | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | | Length of stay in 1b | | c. CITY OR TOWN West Frankfort | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 203 N. Gardner | |
| 3. NAME OF DECEASED (Type or print) First LUTHER Middle NMN Last GOOD | | | | 4. DATE OF DEATH Month JULY Day 21 Year 1960 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 3/30/1887 | 9. AGE (last birthday) 73 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoisting engineer | | | 10b. KIND OF BUSINESS OR INDUSTRY coal mine | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME James Good | | | 13b. MOTHER'S MAIDEN NAME Roxanna Farrar | | | 14. NAME OF HUSBAND OR WIFE Lucretia | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 342-01-8885 | | 17. INFORMANT Phil Ogden, E. St. Louis, 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) BRONCHOPNEUMONIA | | | | | | | 1 WEEK |
| DUE TO (b) PEMPHIGUS | | | | | | | 2 YEARS |
| DUE TO (c) 7041 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC BRAIN SYNDROME DUE TO ARTERIOSCLEROSIS | | | | | | | 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 MAY 23, 1943 to JULY 21, 1960 and last saw her him alive on JULY 21, 1960 Death occurred at 6:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) M. D. | | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 7/22/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 7/25/60 | 23c. NAME OF CEMETERY OR CREMATORY Denning | | 23d. LOCATION (City, town, or county) West Frankfort Illinois | | (State) | |
| 24. FUNERAL DIRECTOR Fred Reedy, West Frankfort, Ill. | | | 25. DATE RECD. BY LOCAL REG. JUL 25 1960 | | 26. REGISTRAR'S SIGNATURE <i>Roald Smith, M.D.</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. J. B

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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Not Embalmed

Signed

Phillip H. Ogden

Licensed Embalmer No. Ill. 7091

P. O. Address 37 Hilltoppl. E.

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.