

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 8 1960

-60-028869

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7197 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill. now</u> COUNTY <u>HAMILTON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>10 Weeks</u>	c. CITY OR TOWN <u>McLeansboro</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>Alexian Brothers Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>606 E MARKET</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ben</u> Middle <u>E.</u> Last <u>Threlkeld</u>			4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>
13a. FATHER'S NAME <u>ISAAC THRELKELD</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN McGUIRE</u>		14. NAME OF HUSBAND OR WIFE <u>BERTHA</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>353-09-5079A</u>		17. INFORMANT <u>Irl Farlow,</u> Address _____	
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>Cardiac Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease yrs.</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None 420.0</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 _____ 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 <u>5/4/60</u> to <u>7/18/60</u> and last saw her/him alive on <u>7/18/60</u> Death occurred at <u>10:55</u> <input checked="" type="checkbox"/> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Anna E. [Signature]</u>			22b. ADDRESS <u>906 Olive St. St. Louis, Mo.</u>		22c. DATE SIGNED <u>7/19/60</u>
23a. Remove PREPARATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ph. Lips Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Co. Benton, Ill.</u>	
24. FUNERAL DIRECTOR <u>Donelson Funeral Home, McLeansboro,</u>		ADDRESS <u>Illinois</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 19 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>MSB</u>

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 *Kenneth Trovly*

Licensed Embalmer No. 4356

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.