

INDEXED

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis		Length of stay in 1b 6 Wks.	c. CITY OR TOWN EAST ST. LOUIS, ILL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN WESLODGE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 900 N 74th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Elmer Middle August Last Cowell			4. DATE OF DEATH Month August Day 29 Year 1960	
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5. SEX Male	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 Aug 17 1914	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver - Salesman	10b. KIND OF BUSINESS OR INDUSTRY Ill. Distributing Co	11. BIRTHPLACE (City and state or country) Hecker, ILL	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Isadore Cowell	13b. MOTHER'S MAIDEN NAME Viola Rahn	14. NAME OF HUSBAND OR WIFE Wanda Jean Cowell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 351-01-2296	17. INFORMANT Mrs Wanda Jean Cowell
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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) Subarachnoidal Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Subdural Hemorrhage	
	DUE TO (c) 9119-46	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suffered when struck by car	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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART II or PART III of item 18.) Struck while working at the East St Louis Illinois
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20c. TIME OF INJURY Hour 7:16 a.m. _____ p.m. _____ Month, Day, Year July 1st 1960	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.) 7th East St Louis Illinois	20f. CITY, TOWN, OR LOCATION East St Louis Illinois	COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw her/him live on _____
Death occurred at **1035 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Coroner	22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 8/30/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) 4-1-60	23b. DATE 4-1-60	23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial	23d. LOCATION (City, town, or county) Caseyville Township Ill	(State) _____
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24. FUNERAL DIRECTOR J. Dewey Holten Jr.	ADDRESS 7717 States	25. DATE RECD. BY LOCAL REG. AUG 30 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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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 me
or by Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Halter Mortuary

Licensed Embalmer No. _____

P. O. Address _____

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.