

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.				Length of stay in 1b		c. CITY OR TOWN Illinois Tazewell Morton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 514 East Madison Street,	
3. NAME OF DECEASED (Type or print) First GENEVA Middle LOTHA Last CRUZE				4. DATE OF DEATH Month SEPTEMBER Day 7 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 9/20/1910	
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		9. AGE (last birthday) 49		11. BIRTHPLACE (City and state or country) Bement, Illinois.	
13a. FATHER'S NAME Harley Trent				13b. MOTHER'S MAIDEN NAME Lillian Unknown		12. CITIZEN OF WHAT COUNTRY U.S.A.	
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		14. NAME OF HUSBAND OR WIFE Charles Cruze	
17. INFORMANT Charles Cruze, 514 East Madison Street,				Address Morton, 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) BACTERIAL PNEUMONIA						4 DAS	
DUE TO (b) MYASTHENIA GRAVIS						3 Yrs	
DUE TO (c) 744.0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACUTE ENCEPHALOMALACIA						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 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 July 11, 1960 to Sept. 7, 1960 and last saw her alive on September 7,		Death occurred at 5:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Leonard Berg M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 9/7/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/8/60		23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Morton, Illinois.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.,				25. DATE RECD. BY LOCAL REG. SEP 8 1960		26. REGISTRAR'S SIGNATURE Leon Smith, M.D.	

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Amy C. Moore

Licensed Embalmer No. 4496

P. O. Address St. Louis, Mo.

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.