

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ill.</b> b. COUNTY <b>Marion</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>24 days</b>		c. CITY OR TOWN <b>Centralia City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>540 Gilmour</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>T.</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>9</b> Day <b>5</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-22-83</b>		9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Retd.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist Retd.</b>		11. BIRTHPLACE (City and state or country) <b>Fairfield, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>George W. Hall</b>				13b. MOTHER'S MAIDEN NAME <b>Eveline Downen</b>				14. NAME OF HUSBAND OR WIFE <b>Ida Hall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>332-05-4649</b>		17. INFORMANT <b>Ida Hall</b>		Address <b>Centralia, Ill.</b>					
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) <b>Acute pulmonary edema</b>										<b>Abt. 1 hr.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										Bet. 5 & 10 yr			
DUE TO (b) <b>Congestive heart failure</b>										Bet. 5 & 10 yr			
DUE TO (c) <b>Arteriosclerotic heart disease</b>										Bet. 5 & 10 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute pylonephritis</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <b>420.0</b> <input type="checkbox"/> Yes <input 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 <b>8/10/60</b> , to <b>9/5/60</b> and last saw her/him alive on <b>9/5/60</b> Death occurred at <b>3:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>C. D. McMillan, M.D.</i> M.D.						22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>9/5/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-7-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Sandoval Township Marion County Ill</b>							
24. FUNERAL DIRECTOR <b>Queen-Boggs Centralia, Ill.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 6 1960</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JANUARY 1968

**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 James R. Che...  
Licensed Embalmer No. 45  
P. O. Address St. L...

Note: The above **MUST** BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.