

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032528

FILED VS AUG 26 1960

318

1003

8193

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri.		Length of stay in 1b 3 weeks	c. CITY OR TOWN Cypress
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Route No. 1
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle H. Last Lockeby			4. DATE OF DEATH Month August Day 18 Year 1960			
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 1/17/1896	9. AGE (last birthday) 64	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) Filling Station Operator		10b. KIND OF BUSINESS OR INDUSTRY Gasoline Station		11. BIRTHPLACE (City and state or country) Poke County, Illinois.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William H. Lockeby		13b. MOTHER'S MAIDEN NAME Inda Hart		14. NAME OF HUSBAND OR WIFE Rose H. Lockeby		

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. 330-18-9486	17. INFORMANT William P. Lockeby, Box No.177,	Address DuQuoin, Illinois.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive Heart Failure		24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Atelectasis of lungs	24 hrs
	DUE TO (c) Paralytic Ileus	154 x 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Adenocarcinoma of rectum - metastasis		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 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.)
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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 DuQuoin, Illinois.
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21. I attended the deceased from July 28 to August 18 and last saw him alive on August 18 1960	
Death occurred at 11:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) W. Loughlin M.D.	22b. ADDRESS 508 N Grand Ave	22c. DATE SIGNED 8-19-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/19/60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Vienna, Illinois.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 1700 Washington Blvd.,	25. DATE RECD. BY LOCAL REG. AUG 19 1960	26. REGISTRAR'S SIGNATURE Earl 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4108

P. O. Address St. Louis

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