

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b	c. CITY OR TOWN Taylorville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Glennon Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 901 Hawley
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BETH Middle ANN Last EMMERLING			4. DATE OF DEATH Month September Day 28 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1960	9. AGE (last birthday) IF UNDER 1 YEAR Months 2 Days 29	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illinois	12. CITIZEN OF WHAT COUNTRY U.S.	

13a. FATHER'S NAME John Emmerling		13b. MOTHER'S MAIDEN NAME Ethel Emmerling		14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT John Emmerling, Taylorville, Ill.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital atresia of bile ducts			INTERVAL BETWEEN ONSET AND DEATH Birth
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute gastroenteritis; had duplication of liver and gallbladder previously removed			

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.) 756.2	
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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 _____		COUNTY _____		STATE _____	
21. I attended the deceased from July 2, 1960 to September 28, 1960 and last saw her ^{her} alive on September 28, 1960 Death occurred at 4:09 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) James P. King M.D.		22b. ADDRESS 1465 S. Grand Avenue		22c. DATE SIGNED 9/28/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-28-60		23c. NAME OF CEMETERY OR CREMATORY Taylorville, Ill.	
23d. LOCATION (City, town, or county)		24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. SEP 28 1960	

26. REGISTRAR'S SIGNATURE Loan 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 Elton R. Remel

Licensed Embalmer No. 4285
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.