ILLINOIS DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 19 1960

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9848 STATE FILE NUMBER 60-039581

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b: 1 Week
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Peoples Hospital
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: St. Clair
c. CITY OR TOWN: East St. Louis
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1533 Baker Avenue
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First GEORGE Middle Last BUCHANAN
4. DATE OF DEATH: Month October Day 8 Year 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 7/24/14
9. AGE (last birthday): 46
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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Darling & Co.
11. BIRTHPLACE (City and state or country): Oklona, Miss.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: BENTON BUCHANAN
13b. MOTHER'S MAIDEN NAME: ANNA (UNKNOWN)
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: W. L. Buchanan, Address: 1533 Baker, E.St.L.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): uremia
DUE TO (b): cerebral thrombosis
DUE TO (c): hypertension
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH
332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10/2/60 to 10/6/60 and last saw ~~her~~ him alive on 10/6/60
Death occurred at 7 P.M. 8 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Edgar F. Woodson (Degree or title) M.D.
22b. ADDRESS: 1516 E. Broadway
22c. DATE SIGNED: 10-5-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/11/60
23c. NAME OF CEMETERY OR CREMATORY: Booker Washington
23d. LOCATION (City, town, or county) (State): Centreville Township, Ill.
24. FUNERAL DIRECTOR: Mariont Officer ADDRESS: 2114 Missouri E. St. Louis
25. DATE RECD. BY LOCAL REG.: OCT 11 1960
26. REGISTRAR'S SIGNATURE: Hoad Smith, M.D.

DOCUMENT

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_____ Signed Frank Prokopf

Signature of Student Embalmer

Licensed Embalmer No. 4356

P. O. Address St Louis

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