

FILED VS OCT 1 9 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9636 STATE FILE NUMBER

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

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| 3. NAME OF DECEASED (Type or print)<br>First <u>Michael</u> Middle <u>J.</u> Last <u>Tierney</u>               |                                  |   | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>2</u> Year <u>1960</u> |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10/4/1915</u>                                   | 9. AGE (last birthday)<br><u>44</u>                   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Teamster</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Construction</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Joliet, Illinois.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>          |  |
| 13a. FATHER'S NAME<br><u>James Tierney</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Rose Kolb</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Mary E. Tierney</u> |  |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No. <u>Nil.</u> | 16. SOCIAL SECURITY NO.<br><u>Unknown</u> | 17. INFORMANT<br><u>Mary E. Tierney, Carlyle, Illinois.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)              |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral subdural hematoma</u> |  |                                  |
| DUE TO (b) <u>Bilateral Subdural Hematomas</u>   |  |                                  |
| DUE TO (c) <u>904.9-45</u>   |  |                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Unknown</u> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.)<br><u>Fall (further details unknown)</u> |
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| 20c. TIME OF INJURY<br>Hour <u>10:20</u> a.m. <u>2:00</u> p.m. <u>6:00</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>above information per family physician</u> | 20f. CITY, TOWN, OR LOCATION<br><u>Carlyle, Carlyle, Ill. Illinois</u> |
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| 21. I attended the deceased <u>admitted dead 7 P.M. 10-2-60 St. John's Hosp</u> her <u>St. Louis, Mo.</u> |
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| 22a. SIGNATURE<br><u>Francis P. Nash</u> | 22b. ADDRESS<br><u>100 N. Euclid</u> | 22c. DATE SIGNED<br><u>10/3/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 23b. DATE<br><u>10-3-60</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary's Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Carlyle, Illinois.</u> |
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| 24. FUNERAL DIRECTOR<br><u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>OCT 3 1960</u> | 26. REGISTRAR'S SIGNATURE<br><u>Kean Smith, M.D.</u> |
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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 J. W. B. Binkley  
Licensed Embalmer No. 265  
P. O. Address St Paul

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.