

FIRST DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043881

FILED VS. NOV 17 1960

318

Primary Registration District No.

1003

Registrar's No.

10741

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		Length of stay in 1b		c. CITY OR TOWN <u>East St. Louis Ill.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Firmin DesLoge</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>47 Delores Drive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>IDVELL</u> Middle <u>LOURWOOD</u> Last <u>LOURWOOD</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1960</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-1897</u>			
				9. AGE (last birthday) <u>63</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (City and state or country) <u>Christian County Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Joseph Stone</u>			13b. MOTHER'S MAIDEN NAME <u>Mattie Cherry</u>			14. NAME OF HUSBAND OR WIFE <u>Widowed</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>487-40-4758</u>		17. INFORMANT <u>Robert Lourwood 47 Delores Dr. Ill</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>POST NECROTIC CIRRHOSIS + STATUS POST OPERATIVE PORTO-CAVAL SHUNT;</u>							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>581-0</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>10/17/60</u> to <u>11/3/60</u> and last saw her alive on <u>11/3/60</u> Death occurred at <u>2:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Dorothy A. Kennedy, M.D.</u>				22b. ADDRESS <u>1325 S. Grand Blvd.</u>				22c. DATE SIGNED <u>11/3/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-7-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, County Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>McLaughlin 2301 Lafayette Ave</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 7 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

61 24 610

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 H. G. Farris

Licensed Embalmer No. 3354

P. O. Address H. G. Farris

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.