

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044456  
STATE FILE NUMBER

FILED VS DEC 12 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3425

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in lb <u>5 1/2 Months</u>	c. CITY OR TOWN <u>Edwardsville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Peace Haven Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Feldman</u> Last <u>Feldman</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Madison Co., Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Herman H. Hurlbrink</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Schafer</u>		14. NAME OF HUSBAND OR WIFE <u>John Feldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>John Feldman, RED #1 Edwardsville, Ill.</u> Address <u>  </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>Carcinoma of Breast</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>					
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. <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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>					
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>11/24/60</u> to <u>11/26/60</u> and last saw her <u>alive</u> on <u>11/26/60</u> Death occurred at <u>  </u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Charles Beumach M.D.</u>			22b. ADDRESS <u>206 W Argonne Northwood 22 RD</u>		22c. DATE SIGNED <u>11/26/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls E &amp; R</u>		23d. LOCATION (City, town, or county) (State) <u>Edwardsville Twp. Co. Ill.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Weber Funeral Home, Edwardsville</u>			25. DATE RECD. BY LOCAL REG. <u>11-26-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

Ill Licensed Embalmer's Statement on Reverse Side

**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 Philip H. Weber

Licensed Embalmer No. 4985

P. O. Address 132 E High  
Cleveland

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.