

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

VS JAN 16 1961
AMENDED

-61-003176
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 174

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Randolph</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b	c. CITY OR TOWN <u>Sparta</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>EDWARD</u> Last <u>HEIN</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>5</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1902</u>	9. AGE (last birthday) <u>58</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>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (City and state or country) <u>Sparta, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Fred Hein</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Robert Hein, New Athens, Ill.</u>		17. INFORMANT Address		17. INFORMANT Address	
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 BLADDER WITH WIDESPREAD METASTASES</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>
DUE TO (b) _____					
DUE TO (c) _____					<u>181.0</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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)	
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>DECEMBER 12, 1960</u> to <u>JAN. 5, 1961</u> and last saw her alive on <u>JAN. 5, 1961</u> Death occurred at <u>11:15 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. D. Vermillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>1/6/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Caledonia Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sparta, Ill.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 6 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSOURI
DEPARTMENT OF HEALTH

NO. _____
DATE _____
LOCALITY _____
NAME OF DECEASED _____
AGE _____
SEX _____
RACE _____
RELIGION _____
CAUSE OF DEATH _____
MANNER OF DEATH _____
PLACE OF DEATH _____
PLACE OF BURIAL _____

TO BE COMPLETED BY THE LICENSED EMBALMER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harry E. Inoué

Licensed Embalmer No. 4495

P. O. Address St. Louis, Mo.

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.