

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4768

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

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>Madison</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>22 days</u>		c. CITY OR TOWN <u>Collinsville</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>Jewish</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>816 Ohio Ave.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>LETHA VIOLA CLINE</u>				4. DATE OF DEATH Month Day Year <u>5 18 1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</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>3-24-12</u>		9. AGE (last birthday) <u>49</u>		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) <u>Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dress Mfg. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Owensville, Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>James Wesley Rogers</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Lee</u>				14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						17. INFORMANT <u>RUBEN</u> Address <u>Stinchfield, Collinsville, Ill.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>BASILARY ARTERY THROMBOSIS</u>										<u>2 weeks</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>										<u>Several years</u>			
DUE TO (c) <u>332x</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					
<u>ARTERIOSCLEROTIC HEART DISEASE (Congestive failure)</u>													
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>12/30/1959</u> to <u>5/18/1961</u> and last saw her ^{her} alive on <u>5/18/1961</u> Death occurred at <u>2:15 P.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>Robert Rubin M.D.</u>						22b. ADDRESS <u>4646 LINCOLL, ST LOUIS, MO</u>			22c. DATE SIGNED <u>5/19/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)						
<u>Burial</u>		<u>5/22/61</u>		<u>Bethel Chapel</u>			<u>Owensville, Indiana</u>						
24. FUNERAL DIRECTOR <u>Herbert K. ...</u>				ADDRESS <u>Collinsville, Ill.</u>				25. DATE RECD. BY LOCAL REG. <u>MAY 19 1961</u>		26. REGISTRAR'S SIGNATURE <u>Leon Smith. M.D.</u>			

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. 2803

P. O. Address Collinsville, Ill

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.