

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

XC 20 171 088

318

SL 25724

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61-023333

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

6188

FILED JUL 7 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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>MACOUPIN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in lb <u>38 DAYS</u>		c. CITY OR TOWN <u>VIRDEN</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>VETERANS ADMIN HOSPITAL</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1037 N. SPRINGFIELD ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>W.</u> Last <u>WHITLOCK</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>61</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</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>12-23-86</u>	9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>CARLINVILLE, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>WILLIAM A. WHITLOCK</u>			13b. MOTHER'S MAIDEN NAME <u>HARRIETT DEFFENBAUGH</u>			14. NAME OF HUSBAND OR WIFE <u>FRANCES WHITLOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>WNI</u>		17. INFORMANT <u>FRANCES WHITLOCK</u> <u>1037 N. SPRINGFIELD ST</u> <u>VIRDEN, 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>BRAIN DAMAGE</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS BRAIN TUMOR</u> <u>AND OR CANCER OF LUNG SUSPECTED.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>450/DH</u>					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 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.) <u>450/DH</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED 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. <u>NA</u> attended the deceased from <u>5-25-61</u> to <u>7-1-61</u> Death occurred at <u>10:35 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>William A. Bushe M.D.</u>			22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>			22c. DATE SIGNED <u>7-1-1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>7-2-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VIRDEN CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>VIRDEN, ILLINOIS</u>		
24. FUNERAL DIRECTOR <u>Paul J. Genoski</u>		ADDRESS <u>St. Louis</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 3 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>	

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 me,
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Paul J. [Signature]*
Licensed Embalmer No. 2398
P. O. Address _____

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.

V