

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023612

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1633

STATE FILE NUMBER

AMENDED

FILED JUN 21 1961

| | | | |
|---|----------------------------|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY | <u>St. Louis</u> | a. STATE | <u>Illinois</u> b. COUNTY <u>Randolph</u> |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | <u>Richmond Heights</u> | c. CITY OR TOWN | <u>Percy</u> |
| Length of stay in 1b | <u>3 weeks</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>St. Mary's Hospital</u> | d. STREET ADDRESS | (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|-----------------------------------|--|-----------------------------|--------------------------------------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First | Middle | Last | Month | Day | Year |
| <u>Ora</u> | <u>Lickiss</u> | <u>Underwood</u> | <u>June</u> | <u>10</u> | <u>1961</u> |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| <u>Male</u> | <u>White</u> | | <u>3/1/1912</u> | <u>49</u> | <u>Mechanical Engineer</u> |
| 10a. USUAL OCCUPATION | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY | | |
| | <u>Industrial Supply</u> | <u>Percy, Ill.</u> | <u>U.S.</u> | | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | |
| <u>Ora S. Underwood</u> | | <u>Hattie B. Lickiss</u> | | <u>Dora Mae Underwood</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. | | 17. INFORMANT Address | |
| <u>No</u> | | | | <u>Hattie Underwood, Percy, 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) Obstruction of 4th ventricle, brain, due to post meningio-encephalitic adhesions

INTERVAL BETWEEN ONSET AND DEATH 6 weeks

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO (b) _____

DUE TO (c) _____

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.

Yes No 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 | 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 |
| | | <u>5/25/61</u> to <u>6/10/61</u> and last saw him alive on <u>6/9/61</u> | | |
| 21. I attended the deceased from _____ Death occurred at <u>1:45 am</u> _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

| | | |
|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) | 22b. ADDRESS | 22c. DATE SIGNED |
| <u>Thomas W. Parker M.D.</u> | <u>4660 Maryland St. St. Louis 8, Mo</u> | <u>6/12/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY |
| <u>Removal</u> | <u>6-13-61</u> | <u>IOOF Cemetery</u> |
| 24. FUNERAL DIRECTOR | 23d. LOCATION (City, town, or county) | 25. DATE RECD. BY LOCAL REG. |
| <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u> | <u>Percy, Ill.</u> | <u>6-12-61</u> |

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Robert M. Murray

Licensed Embalmer No. 3749

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.