

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027591
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2207

AMENDED

FILED AUG 11 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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>Ill.</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES, MO.</u>		Length of stay in lb <u>1428 days</u>	c. CITY OR TOWN <u>CARBONDALE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Greenwood Home & Hospital</u>		d. STREET ADDRESS <u>413 WEST MAIN</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIS</u> Middle <u>G</u> Last <u>CISNE</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</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>FEB 13-1875</u>
9. AGE (last birthday) <u>86</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>PRINCIPAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GRADE SCHOOL</u>	11. BIRTHPLACE (City and state or country) <u>CISNE Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>JONAH CISNE</u>	
13b. MOTHER'S MAIDEN NAME <u>SEVILLA TOWNS</u>		14. NAME OF HUSBAND OR WIFE <u>MRS ANNIE LAURIE CISNE</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 Address <u>MRS ANNIE L. CISNE CARBONDALE 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>Myocardial insufficiency</u> <u>bilateral hypostatic pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized & cerebral arteriosclerosis</u> <u>chronic brain syndrome due to Cereb. accident</u>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input 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 _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
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>Sept. 9-57</u> to <u>Aug. 4-61</u> and last saw him alive on <u>Aug. 4</u> Death occurred at <u>2:45 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Last name or title) <u>Thomas J. [Signature]</u>		22b. ADDRESS <u>1300 Grant Rd.</u>	22c. DATE SIGNED <u>8-4-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>8/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CARBONDALE ILLINOIS</u>
24. FUNERAL DIRECTOR ADDRESS <u>[Signature] Carbondale Illinois</u>		25. DATE RECD. BY LOCAL REG. <u>8-4-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

AUG 17 1961

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 Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed [Signature]
Licensed Embalmer No. F-800
P. O. Address 1101 NTH 9TH

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.