

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-18017920 SL 23146

-61-030911

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7861**

FILED AUG 31 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS COUNTY CLINTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO		Length of stay in 1b 5 DAYS	c. CITY OR TOWN KEYESPORT Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADMIN. HOSPT.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) GENERAL DELIVERY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ARTHUR Middle LEE Last LITTELL			4. DATE OF DEATH Month AUGUST Day 22 Year 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/31/31	9. AGE (last birthday) 30 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) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) KEYESPORT, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME SILAS LITTELL		13b. MOTHER'S MAIDEN NAME LEONA STONE		14. NAME OF HUSBAND OR WIFE DELORIS LITTELL	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES KOREAN		17. INFORMANT Address DELORIS LITTELL, WIDOW, SEE #2
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORME		INTERVAL BETWEEN ONSET AND DEATH 14 MTHS.
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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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 _____
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21. NA attended the deceased from 8/17/61 to 8/22/61 and last saw PER him alive on 8/22/61 Death occurred at 10:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) IRA M. DISHOFF, M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 8/22/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-26-61	23c. NAME OF CEMETERY OR CREMATORY McKendree Chapel	23d. LOCATION (City, town, or county) Bond Co., Ill.
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24. FUNERAL DIRECTOR ZIEREN & DAY, CARLYLE, ILLINOIS.	25. DATE RECD. BY LOCAL REG. AUG 23 1961	26. REGISTRAR'S SIGNATURE Kean Smith, M.D.
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

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 Harvey Stahl
Licensed Embalmer No. 4596

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.