SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-034746
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9054

FILED OCT 13 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b: 7 WKS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: DEACONESS HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ILLINOIS b. COUNTY: MADISON
c. CITY OR TOWN: COLLINSVILLE — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 213 PINE LAKE ROAD — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BESSIE Middle LEE Last NORWINE
4. DATE OF DEATH: Month SEPT. Day 30 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/25/02
9. AGE (last birthday): 59
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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): ST LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: JOHN FITZGERALD
13b. MOTHER'S MAIDEN NAME: ELIZABETH PLUMMER
14. NAME OF HUSBAND OR WIFE: JAMES W. NORWINE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: James Norwine Jr. Address: COLLINSVILLE, ILLINOIS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Adenocarcinoma left breast
DUE TO (c): 170 X
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 ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-3-55, to SEPT 30, 1961 and last saw her/him alive on Sept. 30, 1961
Death occurred at 10:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. E. Mueller (Degree or title) M.D.
22b. ADDRESS: 634 N. Grand Blvd.
22c. DATE SIGNED: 10-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: OCT. 3, 1961
23c. NAME OF CEMETERY OR CREMATORY: ST JOHN CEMETERY
23d. LOCATION (City, town, or county) (State): COLLINSVILLE, ILLINOIS

24. FUNERAL DIRECTOR: HERR FUNERAL HOME ADDRESS: COLLINSVILLE, ILLINOIS
25. DATE RECD. BY LOCAL REG.: OCT 2 1961
26. REGISTRAR'S SIGNATURE: Neal Smith, M.D.

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — 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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3577

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.