

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9860 -61-039256
STATE FILE NUMBER

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		a. STATE Illinois b. COUNTY Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		c. CITY OR TOWN Collinsville	
Length of stay in 1b		d. STREET ADDRESS 893 Portland Ave.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		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 HELEN	Middle I.	Last STARK	4. DATE OF DEATH	Month OCTOBER	Day 24	Year 1961
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1921	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner	10b. KIND OF BUSINESS OR INDUSTRY Food Canning Co.	11. BIRTHPLACE (City and state or country) Salem, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Artie Northcutt	13b. MOTHER'S MAIDEN NAME Estella Lee Kinder	14. NAME OF HUSBAND OR WIFE George Stark
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT George Stark, 893 Portland Ave., Collinsville, Ill.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC FAILURE	LESS THAN 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) INTERATRIAL SEPTAL DEFECT	CONGENITAL
	DUE TO (c) 754.3	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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. I attended the deceased from APRIL 2, 1959 to OCTOBER 24, 1961 and last saw her alive on OCTOBER 24, 1961 Death occurred at 2:50 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C.D. Vermillion, M.D.</i> (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/25/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-27-1961	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Lutheran Cemetery	23d. LOCATION (City, town, or county) Collinsville, Ill.	(State)
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24. FUNERAL DIRECTOR <i>Herbert A. Keady, Collinsville, Ill.</i>	25. DATE RECD. BY LOCAL REG. OCT 25 1961	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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 *Pat*, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Herbert A. Keady*

Licensed Embalmer No. *2803*

P. O. Address *Collinsville,*

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.