

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-042526
STATE FILE NUMBER

318

1003

10599

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Salem	
Length of stay in 1b 1 Month		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 614 N. Broadway	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARGARET Middle HOLT Last HOLT			4. DATE OF DEATH Month NOV Day 14 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1906	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Walkerville, Canada		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Albert Lassoline	13b. MOTHER'S MAIDEN NAME Minnie Pitre	14. NAME OF HUSBAND OR WIFE -----
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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	16. SOCIAL SECURITY NO. -----	17. INFORMANT JoAnne Holt	Address Oak Park, Illinois
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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) Undifferentiated Carcinoma of esophagus		INTERVAL BETWEEN ONSET AND DEATH 3 mo
DUE TO (b) _____		
DUE TO (c) 150+		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Aspiration Pneumonia, anastomotic fistula	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 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 11 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 October 10, '61 to Nov 14 '61 and last saw her/him alive on Nov. 14, 1961
Death occurred at 2:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Martin Bergmann MD	22b. ADDRESS 4409 W Pine	22c. DATE SIGNED 11/15/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-17-1961	23c. NAME OF CEMETERY OR CREMATORY Vernon Cemetery	23d. LOCATION (City, town, or county) (State) Marion County, Illinois
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24. FUNERAL DIRECTOR Bowman-Hancock, Salem, Illinois	25. DATE RECD. BY LOCAL REG. NOV 15 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 Mat Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Kasky III
Licensed Embalmer No. 5039

P. O. Address E. St. Fe

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.