OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-042550
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10549

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 Macoupin

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Length of stay in 1b 6 weeks

c. CITY OR TOWN Gillespie — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St.John's Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 305 W. Pine — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Marian Middle Lorene Last Isaacs

4. DATE OF DEATH Month November Day 11, Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 6/13/1896

9. AGE (last birthday) 65 — 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 At Home

11. BIRTHPLACE (City and state or country) New Douglas, Ill.

12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME Robert W.Livingston

13b. MOTHER'S MAIDEN NAME Lilly Bell Olive

14. NAME OF HUSBAND OR WIFE F.Dwight Isaacs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

17. INFORMANT Address William O.Livingston, Gillespie, Ill.

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) Cerebellar Sarcoma with

DUE TO (b) Metastases to Spinal Cord

DUE TO (c) 193.0

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 months

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 10-4-61, to 11-11-61 and last saw her alive on 11-10-61

Death occurred at 7:50 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl J Reis MD

22b. ADDRESS 18 S Kingshighway

22c. DATE SIGNED 11-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11-14-61

23c. NAME OF CEMETERY OR CREMATORY New Douglas Cemetery

23d. LOCATION (City, town, or county) (State) New Douglas, Ill.

24. FUNERAL DIRECTOR ADDRESS Wiese Funeral Home, Gillespie, Ill.

25. DATE RECD. BY LOCAL REG. NOV 13 1961

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

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

Not Embalmed
Lawrence G. Meye

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.