

DATE AWIENED  
 INSTAED OF  
 SHOULD READ  
 ITEM NO.

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

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 <b>ST. LOUIS, MISSOURI</b>			Length of stay in 1b		c. CITY OR TOWN <b>Illinois St. Clair</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>17 Lakewood Dr.</b>
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>F.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>14</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-31-1893</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ava, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Wesley Wagner</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Modglin</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Elmer Ross</b> Address <b>Belleville, Ill.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC AND RHEUMATIC HEART DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YRS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>420.0</b>
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	
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.)	
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
21. I attended the deceased from <b>SEPT. 28, 1961</b> to <b>NOV. 14, 1961</b> and last saw her/him alive on <b>NOV. 14, 1961</b> Death occurred at <b>9:45 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>C. D. Smith, M.D.</i> M. D.			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>11/14/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 15, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Garden</b>		23d. LOCATION (City, town, or county) (State) <b>St. Clair County, Ill.</b>	
24. FUNERAL DIRECTOR <b>Burke Funeral Home</b> ADDRESS <b>E. St. Louis</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 15 1961</b>	26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>		

**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 Chas M. Burke

Licensed Embalmer No. 2421

P. O. Address \_\_\_\_\_

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.