

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-024639

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5758**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 18 1962

1. PLACE OF DEATH (Where deceased lived. If institution: Residence before admission)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE ILLINOIS b. COUNTY Cokes	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN MATTOON	
Length of stay in 1b 2 WKS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First JACQULYN	Middle RAE	Last GANLEY	Month JUNE	Day 8
			Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-7-1946	9. AGE (last birthday) 15 YR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) MATTOON, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME JACK GORDON GANLEY		13b. MOTHER'S MAIDEN NAME MARY M. Mc Dowell		14. NAME OF HUSBAND OR WIFE -
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. None	17. INFORMANT JACK GANLEY Address MATTOON, ILL	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA	DUE TO (b) ACUTE MONOCYTTIC LEUKEMIA	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		3 MONTHS
DUE TO (c) 204.2		

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 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
---	--	---

21. I attended the deceased from **APRIL 17, 1962** to **JUNE 8, 1962** and last saw her alive on **JUNE 8, 1962**
 Death occurred at **4:15 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. D. Vanillan, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/8/62
--	-------------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-9-62	23c. NAME OF CEMETERY OR CREMATORY Dodge Grove Cem	23d. LOCATION (City, town, or county) (State) MATTOON ILLINOIS
--	-------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Mitchell-Jordan MATTOON	25. DATE RECD. BY LOCAL REG. JUN 9 1962	26. REGISTRAR'S SIGNATURE Hoan Smith M.D.
---	--	--

VS 300 Rev. 4/59

1
812077

3

4 1

5 0

6

7 1

8 1

9

10

11

12 52-0

13

52

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Prokoff

Licensed Embalmer No. 4356

P. O. Address St. Louis, Mo

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.