

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9530

-62-036255

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED OCT 11 1962**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>New Athens</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cardinal Glennon Memorial Hospital for Children</b>		d. STREET ADDRESS (If outside, give location) <b>109 N. Benton</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Gerald William Hess</b>			4. DATE OF DEATH Month Day Year <b>October 4, 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-62</b>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Illinois</b>	
13a. FATHER'S NAME <b>Charles G.</b>		13b. MOTHER'S MAIDEN NAME <b>Monica D. (Eberle)</b>		14. NAME OF HUSBAND OR WIFE <b>Monica Hess</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>New Athens, Ill.</b>	
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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) <b>Cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Congenital Heart Disease</b>		
DUE TO (c) <b>De primary valve atherosclerosis &amp; atrial septal defect</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>754.3</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <b>New Athens, Ill.</b>	COUNTY	STATE
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21. I attended the deceased from **9-25-62** to **10-4-62** and last saw her/him alive on **10-4-62**  
Death occurred at **11:45 Pm** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Joseph J. Sobush, Jr., M.D.</b>	(Degree or title)	22b. ADDRESS <b>1465 S. Grand</b>	22c. DATE SIGNED <b>10/5/62</b>
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23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23c. DATE <b>Oct 5-1962</b>	23d. NAME OF CEMETERY OR CREMATORY <b>St. Agatha's</b>	23e. LOCATION (City, town, or county) (State) <b>New Athens, Ill.</b>
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24. FUNERAL DIRECTOR <b>Hall Funeral Home, New Athens, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 5 1962</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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VS 300 Rev. 4/59  
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 INSTEAD OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 Lee H. Hull

Licensed Embalmer No. 792 Illwin

P. O. Address New Orleans, La.

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.