

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048623

11722

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11722

FILED DEC 18 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>St. Louis</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Length of stay in 1b <u>5 Days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Illinois</u> b. COUNTY <u>St. CLAIR</u></p> <p>c. CITY OR TOWN <u>Caseyville Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>337 Hollywood Hrs. Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last <u>CECIL - NINNESS</u></p>	
<p>4. DATE OF DEATH <u>DECEMBER 5 1962</u></p>	
<p>5. SEX <u>MALE</u></p>	<p>6. COLOR OR RACE <u>white</u></p>
<p>7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input checked="" type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>10-20-1908</u></p>
<p>9. AGE (last birthday) <u>54</u></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST HELPER</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>E. St. Louis, Ill.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u></p>
<p>13a. FATHER'S NAME <u>P. Ernest Ninness</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Iva Mae Jones</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>None</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u></p>
<p>16. INFORMANT <u>Clyde D. Ninness</u> Address <u>Collinsville, Ill.</u></p>	<p>17. INFORMANT Address <u>Collinsville, Ill.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u></p> <p style="text-align: center;">DUE TO (b) <u>RHEUMATIC HEART DISEASE WITH VALVULITIS OF AORTIC, MITRAL AND TRICUSPID VALVES</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>410x</u></p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>
<p>21. I attended the deceased from <u>MARCH 29, 1954</u> to <u>DEC. 5, 1962</u> and last saw her/him alive on <u>DEC. 5, 1962</u></p> <p>Death occurred at <u>12:00 NOON</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>C. D. Vermillion, M.D.</u></p>	<p>22b. ADDRESS <u>BARNES HOSPITAL</u></p>
<p>22c. DATE SIGNED <u>12/6/62</u></p>	<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p>
<p>23b. DATE <u>12-7-62</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Memorial Gardens</u></p>
<p>23d. LOCATION (City, town, or county) (State) <u>Belleville Ill</u></p>	<p>24. FUNERAL DIRECTOR <u>Robins</u> ADDRESS <u>E. St. Louis, Ill</u></p>
<p>25. DATE RECD. BY LOCAL REG. <u>DEC 7- 1962</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u></p>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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MEDICAL CERTIFICATION

SHOULD READ

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USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

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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 Prohoff

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.