

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10099

State File No. _____
Registrar's No. 2563

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>MO</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST Louis</u> | |
| c. LENGTH OF STAY (In this place) <u>5 days</u> | | d. STREET ADDRESS (If rural, give location) <u>3400 Kline</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Childrens Hospital</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>Ronny</u> | | b. (Middle) <u>Dale</u> | |
| c. (Last) <u>Gregory</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>3 - 20 - 49</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>W</u> | 8. DATE OF BIRTH <u>9-12-1946</u> |
| 9. AGE (In years last birthday) <u>2 years 8</u> | | IF UNDER 1 YEAR Days <u>8</u> IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) <u>Cutler</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

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|---|--|-----------------------------------|
| 13a. FATHER'S NAME <u>Gaylord Gregory</u> | 13b. MOTHER'S MAIDEN NAME <u>Nellie Foster</u> | 14. NAME OF HUSBAND OR WIFE _____ |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Gaylord Gregory</u> | ADDRESS <u>3400 Kline</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis, bacterial, generalized</u> | | <u>5 days</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute appendicitis, perforated</u> DUE TO (c) <u>12.1</u> | | <u>8 days</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>5500</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____ |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.

| | | |
|---|--|---------------------------------|
| 23a. SIGNATURE <u>Lawrence W. O'Neal M.D.</u> (Describe or title) | 23b. ADDRESS <u>Childrens Hospital</u> | 23c. DATE SIGNED <u>3-21-49</u> |
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|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>3-23-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Van Buren</u> | 24d. LOCATION (City; town, or county) (State) <u>MO</u> |
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|--------------------------------|---|--|-------------------------------|
| DATE REC'D BY LOCAL REG. _____ | REGISTRAR'S SIGNATURE <u>J B Foster</u> | FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service</u> | ADDRESS <u>404 Manchester</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2563

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.

Signed _____

J. Allen Davis Jr

Signed _____
Student Embalmer

Licensed Embalmer No. 4053

P. O. Address St Louis 10 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 this body is not embalmed, fact should be so stated above.

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