

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28080**
7526
Registrar's No.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon	
c. LENGTH OF STAY (in this place) 4 days		d. STREET ADDRESS (If rural, give location) NR - 205 Duff St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital			
3. NAME OF DECEASED a. (First) Earl b. (Middle) James c. (Last) Gilstrap			4. DATE OF DEATH (Month) (Day) (Year) September 1, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 25, 1884
9. AGE (in years) (Month) (Day) (Year) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	11. BIRTHPLACE (State or foreign country) Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY State Highway Patrol	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Martin Gilstrap		13b. MOTHER'S MAIDEN NAME Theresa Jane Unk.	14. NAME OF HUSBAND OR WIFE Nettie Gilstrap
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Nettie Gilstrap, Macon, Missouri
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Spinal cord tumor INTERVAL BETWEEN ONSET AND DEATH 2 1/2 - 3 yrs. *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 9/1/49		19b. MAJOR FINDINGS OF OPERATION As above	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 56			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 223X			
22. I hereby certify that I attended the deceased from Aug. 28 , 19 49 , to Sept 1 , 19 49 , that I last saw the deceased alive on Sept 1 , 19 49 , and that death occurred at 12 Noon , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) F. P. Bonakky		23b. ADDRESS Barnes Hospital	
23c. DATE SIGNED 9/2/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9-1-49	
24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Macon, Missouri	
DATE REC'D BY LOCAL REG. SEP 2 1949		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington	

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gay W Wilkins

Licensed Embalmer No. 3576

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 this body is not embalmed, fact should be so stated above.