

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6585

FILED FEB 24 1950

State File No. 1370

318

1003

BIRTH NO. 11965-50 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis                                |  |
| c. LENGTH OF STAY (in this place) 3 hrs  |  | d. STREET ADDRESS (If rural, give location) 2269 0 26 917a Benton   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital                        |  |   |  |

|   |                        |   |  |                                   |                               |
|---|------------------------|---|--|-----------------------------------|-------------------------------|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) GARY b. (Middle) ALONZO c. (Last) PADGETT         |                        |   | 4. DATE OF DEATH (Month) (Day) (Year)<br>2-10-50         |                                   |                               |
| 5. SEX Male   | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH 2-10-50                                 | 9. AGE (in years last birthday) 5 | IF UNDER 1 YEAR Months Days 3 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn |                        | 10b. KIND OF BUSINESS OR INDUSTRY                             | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. |                                   | 12. CITIZEN OF WHAT COUNTRY?  |

|                                   |  |                             |
|-----------------------------------|--|-----------------------------|
| 13a. FATHER'S NAME Alonzo Padgett | 13b. MOTHER'S MAIDEN NAME Irene Marshall | 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) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Mrs. A.H. Padgett, 917a Benton, St. | ADDRESS |
|--|-------------------------|---|---------|

|   |  |  |   |
|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, 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*<br>① <i>Subarachnoid and intracerebral hemorrhage</i><br>ANTECEDENT CAUSES<br><i>hemorrhage</i><br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <i>Prematurity 8 mo.</i><br>DUE TO (c) <i>Toxemia, Hypertension in</i> |  |   |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><i>mother - breech position</i><br><i>Walking Breech Position</i>   |  |   |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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) 7605 |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) | 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 2-10-50, 1950, to 2-10, 1950, that I last saw the deceased alive on 2-10-1950, and that death occurred at 9:35a m., from the causes and on the date stated above.

|   |   |                          |
|---|---|--------------------------|
| 23a. SIGNATURE John W. Flynn M.D. (Degree or title) | 23b. ADDRESS 1715 So 39th St. St. Louis | 23c. DATE SIGNED 2-10-50 |
|---|---|--------------------------|

|  |                   |   |  |
|--|-------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 2/11/50 | 24c. NAME OF CEMETERY OR CREMATORY Marquette Cemetery | 24d. LOCATION (City, town, or county) (State) Marquette Ill. |
|--|-------------------|---|--|

|   |                                     |  |
|---|-------------------------------------|--|
| DATE RECEIVED BY LOCAL HEALTH DEPT. FEB 11 1950 | REGISTRAR'S SIGNATURE J. B. Basater | FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jas. A. Howard 1619 So. Grand |
|---|-------------------------------------|--|

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

**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 .....  
Student Embalmer

Signed Jos A. Howard.....

Licensed Embalmer No. 4139.....

P. O. Address 1619 S Grand Bl.....

**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.**