

FILED FEB 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2550
486 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy	
c. LENGTH OF STAY (in this place) 4 Hours		4161	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 3501 Central Place	

3. NAME OF DECEASED (Type or Print) Florence I. Gillespie			4. DATE OF DEATH (Month) (Day) (Year) Jan. 16th, 1951			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH April 9th, 1874	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James H. Gillespie	13b. MOTHER'S MAIDEN NAME Alice M. Williams	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Melville A. Ochsner, Exc.,	ADDRESS 722 Chestnut St.
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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, ashenia, 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) _____		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201

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 330 P. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Calvin F. Feutz</i>	(Degree or title) 3	23b. ADDRESS 130. Clark Ave	23c. DATE SIGNED 1/17/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/19/51	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.
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DATE REC'D BY LOCAL REG. JAN 17 1951	REGISTRAR'S SIGNATURE <i>J. B. Insler</i>	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz,	ADDRESS 4828 Natural Bridge Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 5 1951

Carroll

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Ralph C. Lenders*

Signed.....
Student Embalmer

Licensed Embalmer No. *4275*

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.