

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39032

State File No. 10439

FILED DEC 1 1951

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 10439

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
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 Saint Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8544 Park Lane 21.		e. STREET ADDRESS (If rural, give location) 8544 Park Lane, 21	

3. NAME OF DECEASED (Type or Print) a. (First) Anna	b. (Middle) C.	c. (Last) Gilchrist	4. DATE OF DEATH (Month) (Day) (Year) Nov. 22nd, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan. 26th, 1886	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Gilchrist	13b. MOTHER'S MAIDEN NAME Annie Shea	14. NAME OF HUSBAND OR WIFE None
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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 Mabel C. Gilchrist, 8544 Park Lane, 21,	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 8 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arterio Sclerosis		
	DUE TO (c) In Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			10 yrs since 1936

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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? 332X
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22. I hereby certify that I attended the deceased from 7:00, 19 36, to 11:22, 19 51, that I last saw the deceased alive on 11/22, 19 51, and that death occurred at 11:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE Calvin F. Feutz M.D. (Degree or title)	23b. ADDRESS 5329 River View	23c. DATE SIGNED 11/22/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/24/51	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. NOV 24 1951	REGISTRAR'S SIGNATURE Dr. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz, 4828 Natural Bridge Blvd.	ADDRESS
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

5379 / 11/11/11

**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 John A. Mlinar

Licensed Embalmer No. 4186

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.