

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6397**  
Registrar's No. **1371**

FILED MAR 8 1952

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 <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Brentwood</b> <b>4511</b>	
f. STREET ADDRESS (If rural, give location) <b>8653 Rosalie Avenue</b>		/	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GERTRUDE</b> b. (Middle) <b>NMN</b> c. (Last) <b>GARVIN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>2 11 52</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 14, 1879</b>
9. AGE (in years last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Thomas S. Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Martha V. Farrar</b>	14. NAME OF HUSBAND OR WIFE <b>Benjamin F. Garvin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Benjamin F. Garvin</b> ADDRESS <b>8653 Rosalie Avenue</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL VASCULAR ACCIDENT</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> <b>MANY YEARS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>DIABETES MELLITUS</b> <b>MANY YEARS</b>  INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? 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) _____	
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? <b>443X</b>	
22. I hereby certify that I attended the deceased from <b>2/8</b> , 19 <b>52</b> , to <b>2/11</b> , 19 <b>52</b> , that I last saw the deceased alive on <b>2/11</b> , 19 <b>52</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Carl Smith, M.D.</b> (Degree or title)		23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>2/11/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>Feb. 13, 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Alton, Illinois</b>
DATE REC'D BY LOCAL REG. <b>FEB 13 1952</b>	REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C. R. Lupton &amp; Sons</b> ADDRESS <b>7233 Delmar Blvd.</b>	

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

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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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.