

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26380

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6714**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY OR TOWN St Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis	924 9
d. FULL NAME OF HOSPITAL OR INSTITUTION 1118^A N-14		d. STREET ADDRESS (If rural, give location) 25 1118^A N-14	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) MARY	b. (Middle)	c. (Last) GILES	7	2	53
5. SEX Female	6. COLOR OR RACE Cal	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 2-15-1888	9. AGE (in years last birthday) 65	65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) Miner City Miss!		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Jahn Colman	13b. MOTHER'S MAIDEN NAME Margaret HARRIS	14. NAME OF HUSBAND OR WIFE George Giles
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Geo. Giles 1118^A N-14 St

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		INTERVAL BETWEEN ONSET AND DEATH 30 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal Vascular Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension 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 none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 442 X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from **June 1, 1953**, to **July 2, 1953**, that I last saw the deceased alive on **July 2, 1953**, and that death occurred at **6^P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Tracy D. Anderson MD	23b. ADDRESS 826 N Channing	23c. DATE SIGNED 7-6-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-8-53	24c. NAME OF CEMETERY OR CREMATORY National Cem.
		24d. LOCATION (City, town, or county) (State) Jefferson Berrieh Mo

DATE REC'D BY LOCAL REG. JUL 7 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. P. Richardson 2625 Glasgow
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(Licensed Embalmer's Statement on Reverse Side)

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

AD Richardson

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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