

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37199

State File No. ....

FILED OCT 23 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9888</b>	
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. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				* STREET ADDRESS (If rural, give location) <b>4339 West Pine st. 2199</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ELIZABETH</b>		b. (Middle) <b>EMILY</b>		c. (Last) <b>GAMBILL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>OCTOBER 14, 1953</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>3-4-1873</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Doniphan, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Solomon Dudley</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Eagen</b>			14. NAME OF HUSBAND OR WIFE <b>Johnnie Gambill</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 ADDRESS <b>Hospital Records,</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>ACUTE MYOCARDIAL INFARCTION</b>  ANTECEDENT CAUSES <b>Arteriosclerosis</b> DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <b>ACUTE GALL BLADDER DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YEARS</b>  <b>SEVERAL WEEKS</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4201</b>			
22. I hereby certify that I attended the deceased from <b>OCTOBER 14, 1953</b> , to <b>OCTOBER 14, 1953</b> , that I last saw the deceased alive on <b>OCTOBER 14, 1953</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>William N. Blalock M.D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>1953 OCTOBER 14</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>10-15-53</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Corning, Ark.</b>	
DATE REC'D BY LOCAL REG. <b>OCT 16 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Russell-Emmert, Corning, Ark.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed..... *Albert Mayfield*

Licensed Embalmer No. *307*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.