

35387

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 26 1954

State File No. 8703

No. 300
10.48

318

1003

Registrar's No. 8703

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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 ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute To City Hospital		e. STREET ADDRESS (If rural, give location) 3207 South 9th. Street	
3. NAME OF DECEASED (Type or Print) THOMAS		4. DATE OF DEATH (Month) (Day) (Year) September 22, 1954	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 12-25-1894	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Gibson		13b. MOTHER'S MAIDEN NAME Margaret Majors	
14. NAME OF HUSBAND OR WIFE Maggie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. W.W.# 1 329-14-8314		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Maggie Gibson, 3207 S. 9th. St. Louis, Mo.	
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. 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) <u>Cerebral Apoplexy</u> 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 _____ 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? 334x	
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 8:55 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Patrick F. Taylor Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 9-23-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 9-27-1954		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin Funeral Home, Inc. 2301 Lafayette, St. Louis 4, Missouri	
DATE REC'D BY LOCAL REG. SEP 23 1954		REGISTRAR'S SIGNATURE _____	

(Licensed Embalmer's Statement on Reverse Side)

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

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 *A. G. Farris*.....

Licensed Embalmer No. *330*.....

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.