

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42385**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10642**

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) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4936 Terry Av		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED a. (First) Pauline (Type or Print)		b. (Middle) --- c. (Last) Gatewood	
4. DATE OF DEATH (Month) (Day) (Year) November 21, 1954		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH October 15, 1888		9. AGE (In years last birthday) 66 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Claryville, Missouri		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Henry Braig		13b. MOTHER'S MAIDEN NAME Minnie Menke	
14. NAME OF HUSBAND OR WIFE Robert N. Gatewood		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Robert W. Gatewood, 4936 Terry Av	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Ca f uterus with metastases		2 yrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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) (COUNTRY) (STATE) 174X	
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?	

22. I hereby certify that I attended the deceased from **April, 1954** to **Nov 21, 1954**, that I last saw the deceased alive on **Nov 21, 1954**, and that death occurred at **9:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE M. Kimmel		23b. ADDRESS 3409 Union		23c. DATE SIGNED 11-22-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov 24, 1954		24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
24d. LOCATION (City, town, or county) (State) Chester, Illinois					

DATE REC'D BY LOCAL REG. NOV 23 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Heiderwieden F.H. Inc., 1936 St. Louis Av	
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(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. *None*

working under my personal supervision..

Student *[Signature]* *None*
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. *34*

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.