

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. **0413**

FILED FEB 7 - 1955

318

1003

BIRTH NO. **56365-54** 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		c. CITY OR TOWN St Louis	
c. LENGTH OF STAY (in this place)		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 James Philip Hosp		e. STREET ADDRESS (If rural, give location) 3937 Fairport	
3. NAME OF DECEASED (Type or Print) a. (First) Carl b. (Middle) Gillette Jr c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Jan 12 '55	
5. SEX Male	6. COLOR OR RACE 2 Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 18 July 1954
9. AGE (in years last birthday) 5 mo	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and State or Foreign Country) St Louis, Mo	12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Gillette, Carl Dr	13b. MOTHER'S MAIDEN NAME Kathleen Gillette	14. NAME OF HUSBAND OR WIFE	
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 Bethan Gillette ADDRESS 3937 24	
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) Branch Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 491 X	
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 _____, _____, _____, from the causes and on the date stated above.			
23a. SIGNATURE Deputy Registrar		23b. ADDRESS 1300 Clair	
23c. DATE SIGNED 1/17/55			
24a. BURIAL OR CREMATION REMOVAL (Specify) Removal	24b. DATE 17 Jan 55	24c. NAME OF CEMETERY OR CREMATORY McKethick	24d. LOCATION (City, town, or county) (State) Missouri
DATE REC'D BY LOCAL REG. JAN 15 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE M.A. Reliable Funeral Sys ADDRESS 1221 No Taylor	

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 *Paul V. Freeman*.....

Licensed Embalmer No. *4686*

P. O. Address *429 Adams*

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.