

XC 1877923
Reg. 7418 SL 5200

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13336**
Registrar's No. **3924**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CRAWFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 915 North Grand St. Louis, Missouri	c. LENGTH OF STAY (in this place) 38 days	c. CITY OR TOWN DAVISVILLE	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 20
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 0281	

3. NAME OF DECEASED (Type or Print) WILLIAM	a. (First) J.	b. (Middle) GASKILL	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 5-1-55
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 6-16-88	9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and State or Foreign Country) Dennison, Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Gaskill	13b. MOTHER'S MAIDEN NAME Betty Austin	14. NAME OF HUSBAND OR WIFE Catherine Gaskill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. 490147261	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, ST. LOUIS, MO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 minutes
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEMOPERICARDIUM	DUPLICATE		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) EXTERNAL RUPTURE OF DISSECTING ANEURYSM OF ASCENDING AORTA		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	DUE TO (c)		

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? 451X

22. I hereby certify that I attended the deceased from **3-24**, 19**55**, to **5-1**, 19**55**, and that death occurred at **9:35p.**, from the causes and on the date stated above.

23a. SIGNATURE J.T. Karinskas	(Degree or title) M.D.	23b. ADDRESS VAH, ST. LOUIS, MO.	23c. DATE SIGNED 5-2-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal Motor	24b. DATE 5-2-55	24c. NAME OF CEMETERY OR CREMATORY unk	24d. LOCATION (City, town, or county) (State) Steelville, Mo.

DATE REC'D BY LOCAL REG. MAY 3 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd., St. Louis, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 8 1955

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 *David Van Fossan*

Licensed Embalmer No. *424*

P. O. Address *St. Louis, Mo.*

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.