

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20057

State File No. ....

1003

Registrar's No. 4741

FILED JUN 20 1955

318

REG. DIST. NO. PRIMARY REG. DIST. NO.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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 township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>1 Month</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>6212 Clayton Ave.,</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b>		b. (Middle) <b>Wilford</b>		c. (Last) <b>Gilpin</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 30 1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 6, 1875</b>		9. AGE (In years last birthday) <b>79</b> If under 1 year: Months _____ Days _____ If under 1 week: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Conductor</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Samuel Gilpin</b>			13b. MOTHER'S MAIDEN NAME <b>Rose</b>			14. NAME OF HUSBAND OR WIFE <b>Sarah Carroll Gilpin</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Carroll C. Gilpin 6161 Crescent Ave.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Gangreen At Leg</b> DUE TO (c) <b>Femoral artery + vein Thrombosis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic Heart Disease with Atrial Fibrillation</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 hrs.</b> <b>2 1/2 wks</b> <b>2 1/2 wks</b> <b>Many yr.</b>	
19a. DATE OF OPERATION <b>5/24/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Gangreen At Leg. Thrombosis of femoral Vein + Artery</b>				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) <b>454X</b>			
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>454X</b>			
22. I hereby certify that I attended the deceased from <b>5/19, 1955</b> , to <b>5/30, 1955</b> , that I last saw the deceased alive on <b>5/30, 1955</b> , and that death occurred at <b>4:30 P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Max Allen Hat M.D.</b>				23b. ADDRESS <b>216 South Kings Highway</b>		23c. DATE SIGNED <b>5/31/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>June 2, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 31 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister Colonial Mortuary 6161 Chippewa St., St. Louis, Mo.</b>			

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 *Harry J. Skamcke*  
Licensed Embalmer No. *2679*

P. O. Address *7874 59th Ave*

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.