

FILED JUN 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20696

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1357

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>BRIDGETON TOWNSHIP</u>		c. CITY OR TOWN <u>BRIDGETON TOWNSHIP</u>	
c. LENGTH OF STAY (in this place) <u>1 year</u>		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 <u>11227 St. Damain</u>		e. STREET ADDRESS (If rural, give location) <u>11227 St. Damain</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Vernor R. Gandy</u> c. (Last) <u>Gandy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 12, 1955</u>	
---------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 21, 1882</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF OVER 1 HR. Hours _____ Min. _____
--------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-----------------------------------------	--------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Portland Cement Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>Jacob Gandy</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Trowbridge</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Gandy</u>
---------------------------------------	--------------------------------------------------	-------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Martha Gandy, 11227 St. Damain</u>	ADDRESS
--------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------------------------------	---------

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		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Arteriosclerosis</u>		
	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 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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>7</u> m.	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 19, 1955, to June 12, 1955, that I last saw the deceased alive on April 19, 1955, and that death occurred at 11:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Frank Cohen</u>	23b. ADDRESS <u>10517 St Charles Rd St Ann Mo</u>	23c. DATE SIGNED <u>June 13/55</u>
-----------------------------------------------------	---------------------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal via Motor</u>	24b. DATE <u>6-14-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery,</u>	24d. LOCATION (City, town, or county) (State) <u>Lincoln, Illinois</u>
--------------------------------------------------------------------	----------------------------	-----------------------------------------------------------	------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>6/13/55</u>	REGISTRAR'S SIGNATURE <u>Herbert C. Drake, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Math Hermann & Son, Inc., 2161 E. Fair Ave</u>	ADDRESS
-----------------------------------------	-----------------------------------------------------	----------------------------------------------------------------------------------------	---------

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 *W. Gordon G. Bussler*
Licensed Embalmer No. *4426*

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.