

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **30704**FILED SEP 29 1955
BIRTH NO. **72842-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7705**

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. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute to City Hospital		e. STREET ADDRESS (If rural, give location) 2318 South Third 2239			
3. NAME OF DECEASED (Type or Print)		a. (First) GARY		b. (Middle) DEWAYNE	
		c. (Last) COLLIER		4. DATE OF DEATH (Month) (Day) (Year) 8 31 55	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH 9-28-1954		9. AGE (In years last birthday) 11 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Earl Collier	
13b. MOTHER'S MAIDEN NAME Mary Davison		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) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Collier, 2318 South 3rd			
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) Interstitial Pneumonia INTERVAL BETWEEN ONSET AND DEATH 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)		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 <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>100A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE Satruck & Taylor		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 9-2-56	
24a. BURIAL CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-2-1955		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Missouri		DATE REC'D BY LOCAL REG. SEP 2 1955		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F.H., Inc., 2301 Lafayette		(Licensed Embalmer's Statement on Reverse Side)			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

40808

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 *H. G. Farris*

Licensed Embalmer No. *330*

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.