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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 35533

FILED NOV 16 1956 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9298

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): BARNES HOSPITAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Madison
c. CITY OR TOWN: East Alton — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 644 Washington — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Sophia Middle: Isabel F. Last: Gehlert

4. DATE OF DEATH Month Day Year: Oct. 10, 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 30, 1904

9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): Belle, Missouri.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Pointer

14. MOTHER'S MAIDEN NAME: Cynthia Eaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): Nil.

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: William Gehlert, East Alton, Illinois,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myelocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 204.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m., Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept. 30, 1956 to Oct. 10, 1956 and last saw her/him alive on Oct. 10, 1956. Death occurred at 2:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. A. Vermillion M.D. M. D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 10/10/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 10-10-56

23c. NAME OF CEMETERY OR CREMATORY: Local

23d. LOCATION (City, town, or county) (State): Belle, Missouri.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe 4700 Washington,

25. DATE RECD. BY LOCAL REG.: OCT 11 1956

26. REGISTRAR'S SIGNATURE: Pearl Smith Mo. MPB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.