

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2730  
STATE FILE NUMBER

FILED JAN 25 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Adams</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Clayton</b> 8/20 8 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		Length of stay in lb <b>3 days</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Norma</b> Middle <b>Lee</b> Last <b>Gibbs</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1919</b>		9. AGE (In years last birthday) <b>37</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Prudential Ins. Co.</b>	11. BIRTHPLACE (City and state or country) <b>McGee TWP. Adams Co., Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Roll E. Gibbs</b>			14. MOTHER'S MAIDEN NAME <b>Emma Purpus</b>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>	16. SOCIAL SECURITY NO. <b>331-16-1795</b>	17. INFORMANT <b>William M. Gibbs, 919 43rd St.,</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, Subarachnoid, Spont.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Recurrim, Saccular, Rt. internal</b>	<b>indefinite</b>
	DUE TO (c) <b>Carotid artery</b> <b>330X</b>	
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <b>1-1-57</b> to <b>1-3-57</b> and last saw her alive on <b>1-2-57</b> Death occurred at <b>8 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>George E. Roelhae MD</b>	22b. ADDRESS <b>3720 Washington Ave</b>	22c. DATE SIGNED <b>1-3-57</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-3-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>South Side</b>	23d. LOCATION (City, town, or county) (State) <b>Clayton, Illinois.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 5 1957</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1921  
 No. 100  
 State of Ohio  
 Department of Health  
 Bureau of Embalming  
 Certificate of Embalming  
 No. 100-100-100  
 State of Ohio

**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 *G. W. Wilkinson*  
 Licensed Embalmer No. 35

P. O. Address *M. K.*

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.