Health,
& Welfare
Public
Service

S. 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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 14692

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3830

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Mt. Carmel 8120 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL — Length of stay in 1b	d. STREET ADDRESS 32 RR#4 (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
ANNA	ELIZABETH	GALLATIN	APRIL 18, 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
female	white		4-17-1882	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Mt. Carmel, Ill.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Seiler	Sabia Metz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		none	Wilbur Gallatin	

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) PERITONITIS OF BOWEL

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) CARCINOMA OF HEAD OF PANCREAS

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 MOS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 157X

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 MARCH 13, 1957 to APRIL 18, 1957 and last saw her/him alive on APR. 18, 1957. Death occurred at 10:26 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. L. Vermillion, M.D. (Degree or title) M.D.

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 4/18/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal

23b. DATE 4-19-57

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Mt. Carmel, Ill.

24. FUNERAL DIRECTOR Cunningham, Mt. Carmel, Ill. ADDRESS

25. DATE RECD. BY LOCAL REG. APR 22 57

26. REGISTRAR'S SIGNATURE Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

JUN 4 1957

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 459

P. O. Address Flouss

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