THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19007
STATE FILE NUMBER 5272

FILED JUN 14 1957

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

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): ST. LOUIS CITY HOSP. #1. Length of stay in 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY:
c. CITY OR TOWN: St Louis Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 3100 Locust St Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First GEORGE Middle Last MC GINNIS
4. DATE OF DEATH: Month JUNE Day 2 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Sept 15 1895
9. AGE (In years last birthday): 61
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): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Mc Ginnis
14. MOTHER'S MAIDEN NAME: Barbara Ryan
Wife Lennie (Unk)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 488-16-9933
17. INFORMANT: Marie Rothwell Address: 2331 Mullanphy

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): Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c): Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 332x
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 6/1/57 7:15p.m to 6/2/57 and last saw her him alive on 6/2/57
Death occurred at 8:30 P.M m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Stephen A. Bunch, M.D. (Degree or title)
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 6/3/57.
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/5/57
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county): St Louis (State): Mo.
24. FUNERAL DIRECTOR: Cullen & Kelly ADDRESS: 7267 Natl Bridge
25. DATE RECD. BY LOCAL REG.: JUN 5 '57
26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.. Not Embalmed

Student.....
Signature of Student Embalmer

Signed James A. Lammer

Licensed Embalmer No. 4

P. O. Address St Lou

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.