

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

26126

318

1003

6110

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. James		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 Enroute City Hospital		Length of stay in lb	d. STREET ADDRESS 31 206 Charles (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Daughtless Middle W Last Gee			4. DATE OF DEATH Month June Day 29 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16, 1916		9. AGE (In years last birthday) 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Parma Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Columbus Gee			14. MOTHER'S MAIDEN NAME Eva Jenkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Leona Gee Address St. James Mo		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation from aspiration of vomitus; DUE TO (b) of Gastritis; DUE TO (c) Alcoholism 322.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
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 _____ to _____ and last saw her/him alive on _____ Death occurred at 7:50 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Direct or file) Patrick Taylor Carver			22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7.1.57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-1-57	23c. NAME OF CEMETERY OR CREMATORY Ozark Memorial		23d. LOCATION (City, town, or county) (State) Rolla Mo
24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington			25. DATE RECD. BY LOCAL REG. JUL 1 - '57		26. REGISTRAR'S SIGNATURE Carl Smith MO

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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 *Robert M. Murray*
Licensed Embalmer No. *13*
P. O. Address *St. Louis*

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.