

Health, Welfare, Public Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1957

28293
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3627

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If in institution, give name of institution) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City Kinloch	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS 352 Evengreen St 333 Bellefontaine	
3. NAME OF DECEASED (Type or print) First Middle Last Fred Mc Gill		4. DATE OF DEATH Month Day Year July 31, 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1914 April 7, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Match Co.	11. BIRTHPLACE (City and state or country) Camden, Mo.
13a. FATHER'S NAME Frank McGill		13b. MOTHER'S MAIDEN NAME Isora Stevenson	14. NAME OF HUSBAND OR WIFE Flora McGill
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war dates of service) Yes W W 2		16. SOCIAL SECURITY NO. 486-03-7135	17. INFORMANT Flora McGill Address Kinloch, 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) Undetermine. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Probable pontine damage secondary to brain DUE TO (c) trauma from fall during convulsive seizure.			INTERVAL BETWEEN ONSET AND DEATH 3531
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (Epilepsy grand mal)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 July 29, 1957 to July 31, 1957 and last saw her/him alive on July 31, 1957 Death occurred at 10:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.R. Peterson M.D. (Degree or title)		22b. ADDRESS 600 East 22nd Street	
		22c. DATE SIGNED 8-2-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 2, 1957	
23c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Boyd Brothers ADDRESS Kinloch, Mo.		25. DATE RECD. BY LOCAL REG. 8-2-57	
26. REGISTRAR'S SIGNATURE Neva Minshall			

USE ONLY BLACK INK. RUBBON TYPEWRITER IF POSSIBLE. MEDICAL CERTIFICATION: W.R. Peterson

W.R. Peterson

All diseases in Part I must be causally related.



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 *Jerome Minola*

Licensed Embalmer No. *3994*
P. O. Address *3712 E 30th*

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