

Health,
& Welfare
S. Public
Health Service

S. 300
v. 1-56

Securing the medical certification in the specific manner required by 193.140 MoRS 1947.
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

FILED DEC 30 1957

STANDARD CERTIFICATE OF DEATH

45828
STATE FILE NUMBER
12110

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			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis;		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis;		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 Pronounced dead City			Length of stay in lb Hospital # 27		d. STREET ADDRESS 3100 Lawton		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Thomas; Gambie;				4. DATE OF DEATH Month Day Year Dec. 14, 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6 1887		9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City			10b. KIND OF BUSINESS OR INDUSTRY Street Dept.		11. BIRTHPLACE (City and state or country) Hopkinsville, Ky.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Salmon; Gambie				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Lizzie Marshall 1014 S. Ewing			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture dislocation of the 1st and the 2nd cervical vertebra.</i> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last, DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS (Do not report conditions which do not terminate in death. Give in Part 19.) <i>buffered against curb street by car operated by one, Raymond</i>							INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION	19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <i>Charles</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Street and Spruce Streets about</i>				
20c. TIME OF INJURY. Hour - Month, Day, Year 1230 a. m. 12 14 57		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.) <i>Street</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis Mo</i>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>12:55 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Doctor or title) <i>James M Kelly Deputy</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>12-17-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12-18-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery;</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo</i>		
24. FUNERAL DIRECTOR S. J. Watson ADDRESS <i>2769 Chouteau</i>			25. DATE RECD. BY LOCAL REG. <i>DEC 17 57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith No</i>		

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.....
Licensed Embalmer No. 969
P. O. Address 2746

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.