

300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|  |                           |   |   |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN ST. LOUIS, MISSOURI  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN ST. LOUIS, MO.  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION VAH 915 N GRAND AVE.   |                           | Length of stay in lb<br>3 DAYS  | d. STREET<br>ADDRESS 2390 2624 MISSOURI AVENUE  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>JOHN A. GAINES  |                           |   | 4. DATE<br>OF<br>DEATH<br>Month Day Year<br>2/17/58   |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>3/11/98   |
| 9. AGE (In years last birthday)<br>59  |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED LABORER   | 11. BIRTHPLACE (City and state or country)<br>PADUCAH, KENTUCKY   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED LABORER   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13a. FATHER'S NAME<br>WILLIAM GAINES   |                           | 13b. MOTHER'S MAIDEN NAME<br>MARY BLOOM   | 14. NAME OF HUSBAND OR WIFE<br>CANDUS GAINES  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br>YES WW-1  |                           | 16. SOCIAL SECURITY NO.<br>489-05-1727  | 17. INFORMANT<br>Address<br>VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY<br>DUE TO (b) ARTERIOSCLEROSIS<br>DUE TO (c) 332x<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>BRONCHOPNEUMONIA |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>10 years<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> NONE <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<br>Hour Month, Day, Year<br>a.m. p.m.  |                           | 20d. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>WORK 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 2/14/58 to 2/17/58 and last saw him alive on 2/17/58<br>Death occurred at 9:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |   |
| 22a. SIGNATURE<br>(Degree or title)<br>C.E. COOKE M.D.   |                           | 22b. ADDRESS<br>VAH, ST. LOUIS, MO.   | 22c. DATE SIGNED<br>2/17/58   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>removal   | 23b. DATE<br>2-20-58      | 23c. NAME OF CEMETERY OR CREMATORY<br>National Cemetery   | 23d. LOCATION (City, town, or county) (State)<br>Jefferson Barracks, Mo.  |
| 24. FUNERAL DIRECTOR<br>Witt Bros. I&U.Co. ADDRESS 2929 S. Jefferson   |                           | 25. DATE RECD. BY LOCAL REG.<br>FEB 18 '58  | 26. REGISTRAR'S SIGNATURE<br>J. Carl Smith M.D.   |

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 *Howard E. Witt* .....

Licensed Embalmer No. *4353* .....  
P. O. Address *St. Louis, Mo.* .....

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.