Health, & Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-023343
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6636

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY
c. CITY OR TOWN: Gillespi — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): Route # 1 — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First KENNETH Middle ROY Last GURICK
4. DATE OF DEATH: Month JULY Day 1 Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 26, 1913
9. AGE (In years last birthday): 45 — 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): Cabinet Maker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Litchfield, Illinois.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Oscar Gurick
13b. MOTHER'S MAIDEN NAME: Leota Beanblossom
14. NAME OF HUSBAND OR WIFE: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.
16. SOCIAL SECURITY NO. 381-14-0838
17. INFORMANT: Esther Gurick, Address: Gillespie, Illinois.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) SUBDURAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 19 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) RUPTURED ANEURYSM OF ANTERIOR COMMUNICATING ARTERY — 2 YEARS
DUE TO (c) 330 x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PNEUMONITIS, LEFT LOWER LOBE 1 WEEK. GASTROINTESTINAL BLEEDING 2 WKS.
19. WAS AUTOPSY PERFORMED? YES [X] 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 JUNE 13, 1958, to JULY 1, 1958 and last saw her/him alive on JULY 1, 1958
Death occurred at 5:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F. R. Bradley (Degree or title) M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 7/1/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 7-1-58
23c. NAME OF CEMETERY OR CREMATORY Local
23d. LOCATION (City, town, or county) (State) Gillespie, Illinois.

24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG. JUL 2 '58
26. REGISTRAR'S SIGNATURE Earl Smith MD MSB.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 4108

P. O. Address .....

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.