

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037783

STATE FILE NUMBER

FILED OCT 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9720

S. 300  
1-57

All diseases in Part I must be causally related.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Green (Mission)			
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 Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		Length of stay in 1b 6 days		d. STREET ADDRESS 1200 So. Jefferson	
3. NAME OF DECEASED (Type or print) First Middle Last Don Ragain Gaines			4. DATE OF DEATH Month Day Year Oct. 9, 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-51	9. AGE (In years last birthday) 7 yrs	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, if any) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Springfield, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Robert Gaines		13b. MOTHER'S MAIDEN NAME Eleanor Reynolds	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <del>Not known</del> ) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jane Henrichsen-500 So. Kingshighway		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis (post-op Gibbon's pump surgery) open heart</u>		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Tetralogy of Fallot</u>		DUE TO (c) <u>? Cerebral anoxia or thrombus (autopsy)</u>		7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 hrs.	
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.) 7540			
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.) 10-4-58		20f. CITY, TOWN, OR LOCATION 10-9-88		COUNTY STATE 10-9-58	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>2:20 pm.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Wm J Klingberg MD</u>		22b. ADDRESS 600 S. Kingshighway		22c. DATE SIGNED 10-9-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-10-58		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	
23d. LOCATION (City, town, or county) Springfield, Mo.		23e. DATE RECD. BY LOCAL REG. OCT 10 1958		23f. REGISTRAR'S SIGNATURE <u>Earl Smith</u> R.S.	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.			24. REGISTRAR'S SIGNATURE		

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, ~~by~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Laurence O. Heiling* .....

Licensed Embalmer No. *4279* .....  
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.