Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041610

STATE FILE NUMBER 10597

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in 1b: 27 2/12

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1317 N. Whittier — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Gipson

4. DATE OF DEATH: Month 11 Day 3 Year 58

5. SEX: Female 3

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH: 1/26/1886

9. AGE (In years last birthday): 72 — 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): Preacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Corinth, Miss. /

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Henry Stegall

13b. MOTHER'S MAIDEN NAME: Jane Patton

14. NAME OF HUSBAND OR WIFE: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Joseph Green — Address: 4327a Evans Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Sclerosis	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriesclerosis, Generalized	undet.
DUE TO (c)	334x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Multiple Infected Decubiti

19. WAS AUTOPSY PERFORMED? YES ☒ 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 10-19-58, to 11-3-58 and last saw her alive on 11-3-58
Death occurred at 12:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul H. Larson (Degree or title) M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 11-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 6 Nov 58

23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Atkins Bros. — ADDRESS: 3644 Finney Ave.

25. DATE RECD. BY LOCAL REG.: NOV 5 '58

26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. M.S.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed John K Cunningham

Signature of Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 2405 Marca

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.