

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045684

STATE FILE NUMBER

11838

Registration District No. 318 Primary Registration District No. 1003 Registration No. 11838

FILED JAN 5 1959

1. PLACE OF DEATH
a. COUNTY MO.

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis Inside Limits Yes No

c. CITY OR TOWN St. Louis Inside Limits Yes No

f. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION D.O.A. Homer Phillips Length of stay in lb ps d. STREET ADDRESS (If outside, give location) 2259 I 505 1/2 Franklin Ave. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last: Robert Gartrell Jr. 4. DATE OF DEATH Month Day Year 12/9/58

5. SEX Male 2 6. COLOR OR RACE Col. 7. MARRIED NEVER MARRIED WIDOWED 2 DIVORCED 8. DATE OF BIRTH Dec, 10, 1902 9. AGE (In years last birthday) 55 IF UNDER 1 YEAR Months 11 Days 24 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Town Creek, Ala. 11. BIRTHPLACE (City and state or country) USA. 12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Robert Gartrell Sr. 13b. MOTHER'S MAIDEN NAME Janet Smith 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. — 17. INFORMANT Address Mattie S. Simmons 1729 N. Jefferson Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 491X
DUE TO (c) 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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 Month, Day, Year a.m. p.m.

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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) James M. Deely, M.D., Deputy 22b. ADDRESS 1300 Blank 22c. DATE SIGNED 12-8-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 12/12/58 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS Wright Funeral Home 3100 Easton Ave. 25. DATE RECD. BY LOCAL REG. DEC 9 '58 26. REGISTRAR'S SIGNATURE Carl Smith MO

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Arthur L. Heallard*

Licensed Embalmer No. *4221*

P. O. Address *3100 Easton*

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.