

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045685
State File No.

FILED JAN 12 1959

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **12305**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.			c. CITY OR TOWN St. Louis, Mo.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) 10 Years			e. STREET ADDRESS (If rural, give location) 5400 Arsenal St.		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital					
3. NAME OF DECEASED (Type or Print)		a. (First) ELLA Frances	b. (Middle) Elinore	c. (Last) Gatewood	4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sgl.		8. DATE OF BIRTH Sept. 12, 1878	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Klines Store		11. BIRTHPLACE (City and State or Foreign Country) Missouri 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Robert Gatewood		13b. MOTHER'S MAIDEN NAME Mary Josephine DeLassus		14. NAME OF HUSBAND OR WIFE ---	
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. 500-30-5096		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert W. Gatewood - 1900 Bissell Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia					
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					
ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
DUE TO (b) Acute pulmonary embolism, from thrombosis of rt. femoral vein.					
DUE TO (c) Bronchiectasis with abscess formation					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION with cerebral arteriosclerosis			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 26, 1949 , to Dec. 18, 1958 , that I last saw the deceased alive on Dec. 18, 1958 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE Frederich W. Witt, M.D.			23b. ADDRESS 237 N. Euclid		23c. DATE SIGNED 12-18-58
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal VIA MOTOR		24b. DATE Dec. 22, 1958	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24d. LOCATION (City, town, or county) (State) Perryville, Missouri
DATE REC'D BY LOCAL REG. DEC 20 '58		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair	

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 *Clement McNeary*.....

Licensed Embalmer No. *3738*

P. O. Address *St. Louis*

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.