

46425-58

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046770

STATE FILE NUMBER

FILED JAN 6 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3318

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 4311
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteo. Hospt		Length of stay in 1b 30 min.	d. STREET ADDRESS (If outside, give location) 6151 Wagner
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Michael Duane Gift			4. DATE OF DEATH Month Day Year Dec. 17 1958		
--------------------------------------------------------------------------------	--	--	----------------------------------------------------	--	--

5. SEX M <input type="radio"/> F <input type="radio"/> O <input type="radio"/> W <input type="radio"/>	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1958	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR 11	IF UNDER 24 HRS. Hours Min.
-----------------------------------------------------------------------------------------------------------	-----------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------	--------------------------------------	-----------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-----------------------------------------------------------------------------------------------------	-------------------------------------------	---------------------------------------------------	----------------------------------------

13a. FATHER'S NAME Duane Howard Gift	13b. MOTHER'S MAIDEN NAME Ruthene Stringer	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 Nil	16. SOCIAL SECURITY NO. None	17. INFORMANT Duane's wife	Address 6151 Wagner
---------------------------------------------------------------------------------------------------------------------	---------------------------------	-------------------------------	------------------------

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>Cardiac Failure</u> <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>491X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------

21. I attended the deceased from <u>12-17-58</u> to <u>12-17-58</u> and last saw <u>her</u> <u>him</u> alive on <u>12-17-58</u> Death occurred at <u>2:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Mary G. Richardson D.O.</u>	22b. ADDRESS <u>2335 Brown Rd.</u>	22c. DATE SIGNED <u>12-17-58</u>
--------------------------------------------------------------------	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-18-58	23c. NAME OF CEMETERY OR CREMATORY LOCAL	23d. LOCATION (City, town, or county) Mountain View, Mo.
------------------------------------------------------	-----------------------	---------------------------------------------	-------------------------------------------------------------

24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. 12-19-58	26. REGISTRAR'S SIGNATURE <u>Herbert G. Drake M.D.</u>
----------------------------------------------------------------	------------------------------------------	-----------------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Laurence O. Gehring*

Licensed Embalmer No. *4977*
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.