Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002977
STATE FILE NUMBER
2 815

FILED FEB 16 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: DE PAUL HOSP — Length of stay in 1b: 1 DAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY: ST. LOUIS
c. CITY OR TOWN: PINE LAWN — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 6706 JOLIET — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ZOE — Middle: — Last: GLORE

4. DATE OF DEATH: Month: JAN — Day: 23 — Year: 1959

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: MAR 21 1884

9. AGE (In years last birthday): 74 — 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): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (City and state or country): POTOSI - MISSOURI

12. CITIZEN OF WHAT COUNTRY?: U. S.

13a. FATHER'S NAME: JOHN WALKER

13b. MOTHER'S MAIDEN NAME: CINDERILLA DOSS

14. NAME OF HUSBAND OR WIFE: BEN GLORE

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: BEN GLORE, 6106 Joliet ave

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
DUE TO (b): Hypertensive X Arteriosclerotic Cardiovascular Disease — years
DUE TO (c): 443X
(Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)
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 [X]

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 11/5/52 to 1/22/59 and last saw her/him alive on 1/22/59
Death occurred at 1:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert A Baer MD

22b. ADDRESS: 3731 Goodfellow

22c. DATE SIGNED: 1/23/59

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

23b. DATE: 1-26-59

23c. NAME OF CEMETERY OR CREMATORY: CALVARY

23d. LOCATION (City, town, or county) (State): ST. LOUIS - MO

24. FUNERAL DIRECTOR — ADDRESS: L. B. Tanner, 6107 Natural Bridge

25. DATE REC'D BY LOCAL REG.: JAN 24 59

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

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must use only standard nomenclature in Part I. No symptoms may be reported. 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 John S. Dennehy

Licensed Embalmer No. 4194

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.