

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003681
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 317 Primary Registration District No. 531 Registrar's No. 215

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1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>University City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> 2039 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <i>8306 Saville Trumbull</i>		Length of stay in 1b	d. STREET ADDRESS (If outside give location) <i>6041 Elizabeth Ave.</i>

3. NAME OF DECEASED (Type or print) First <i>Lyla</i> Middle <i>Jane</i> Last <i>Tate</i>			4. DATE OF DEATH Month <i>JAN.</i> Day <i>22</i> Year <i>1959.</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 13, 1888</i>	9. AGE (In years last birthday) <i>71</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>9</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (City and state or country) <i>Pickford Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>William H. Gough</i>	13b. MOTHER'S MAIDEN NAME <i>Mary Taylor</i>	14. NAME OF HUSBAND OR WIFE <i>Rev. P. A. Tate</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT <i>Rev. P. A. Tate</i>	Address <i>6041 Elizabeth Ave</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Reticulum cell sarcoma, disseminated</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10-12 mos.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <i>200.0</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic heart disease, compensated.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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 _____
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21. I attended the deceased from *1950* to *1-22-59* and last saw her alive on *1-21-59*.
Death occurred at *9:30 A.M., Jan. 22, 1959* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Carl Maxwell MD</i>	(Degree or title)	22b. ADDRESS <i>4500 Olive St.</i>	22c. DATE SIGNED <i>1-23-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 24/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo</i>
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24. FUNERAL DIRECTOR <i>Bull-Campbell Mortuary</i>	ADDRESS <i>5165 Delmar</i>	25. DATE RECD. BY LOCAL REG. <i>1-23-59</i>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy MD.</i>
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(Licensed Embalmers' Statement on Reverse Side)

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 *Edouard H. Remelius*

Licensed Embalmer No. *4283*

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.