

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007136

STATE FILE NUMBER

2 978

FILED FEB 24 1959

Registration District No.

Primary Registration District No.

Registration No.

300  
-57  
2  
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1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILL.</b> COUNTY <b>ST. CLAIR</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>EAST ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LUKES</b>		Length of stay in lb <b>1 Mo.</b>	d. STREET ADDRESS (If outside, give location) <b>564 N. 26.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>RAYMOND GILL</b>			4. DATE OF DEATH Month <b>1</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 13 1904</b>		9. AGE (In years last birthday) <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life given if retired) <b>LIVESTOCK HANDLER NAT'L STOCKYARD</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>EAST ST. LOUIS ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>CLARENCE GILL</b>		13b. MOTHER'S MAIDEN NAME <b>MOLLY McCORMACK</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>333-18-3616</b>		17. INFORMANT Address <b>Clarence Gill 742 Veronica Pl 614 201</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of Pharynx</b> DUE TO (c) <b>148X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
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 _____ o.m. _____ p.m.					
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	
21. I attended the deceased from <b>9/25/53</b> to _____ and last saw <del>her</del> him alive on <b>1/26/59</b> Death occurred <b>1/26/59</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Donald Matt.</b>		22b. ADDRESS <b>3770 Washington</b>		22c. DATE SIGNED <b>1/28/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>BURIAL</b>		<b>1-29-59</b>		<b>MT. CARMEL</b>	
24. FUNERAL DIRECTOR <b>Nell Walsh Barnes E. St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 28 59</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 Maher*.....

Licensed Embalmer No. *29-829*.....

P. O. Address *East 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.