

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010927
STATE FILE NUMBER
2504

FILED MAR 25 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in 1b 20 Yrs.	d. STREET ADDRESS (If outside, give location) 4431 Vista, Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Myrtle Middle Last Gall			4. DATE OF DEATH Month March Day 9 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1913
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months Days Hours Min.	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 At Home	11. BIRTHPLACE (City and state or country) Salem, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Shelton	
13b. MOTHER'S MAIDEN NAME Edith Purcell		14. NAME OF HUSBAND OR WIFE Adolph Gall	
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. 322-12-1120	17. INFORMANT Adolph Gall, 4431 Vista, Ave. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM TO BRAIN Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ATRIAL FIBRILLATION DUE TO (c) RHEUMATIC HEART DISEASE, INACTIVE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 416x			INTERVAL BETWEEN ONSET AND DEATH 2 YRS. 1 1/2 YRS. 10 YRS.
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 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 January 13, '58 to Mar. 9, 1959 and last saw her/him alive on Mar. 9, 1959 Death occurred at 1:20 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert E. Cook</i> (Degree or title)		22b. ADDRESS 35 N. Central, Clayton, Mo.	22c. DATE SIGNED 3-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-12-59	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. MAR 11 '59	26. REGISTRAR'S SIGNATURE <i>Robert Smith. M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

0 9
1891
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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 *G. W. Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address *M. 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.