

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-15049
STATE FILE NUMBER
2 3965

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's Initials _____

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1201 S. 7th Str.
3. NAME OF DECEASED (Type or print) First Middle Last Phillip H. Gross			4. DATE OF DEATH Month Day Year APRIL 20 59
5. SEX Male <input type="checkbox"/>	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 4/23/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10b. KIND OF BUSINESS OR INDUSTRY Tavern	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Charles Gross		13b. MOTHER'S MAIDEN NAME Matilda ?	14. NAME OF HUSBAND OR WIFE Mary
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 Address Mary Gross 1201 S. 7th Str.
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>Carcinoma of right lung</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			163x
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 <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 <i>April 1955</i> to <i>4/20/59</i> and last saw ^{him} alive on <i>4/20/59</i> Death occurred at <i>2:30</i> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert Potashnick M.D.</i> (Degree or title)		22b. ADDRESS <i>3720 Washington Ave.</i>	22c. DATE SIGNED <i>4/20/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/23/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>	23d. LOCATION (City, town, or country) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Moydell Funeral Home 1926 Allen</i>		25. DATE RECD. BY LOCAL REG. <i>APR 22 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S.P.

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 *Valley F. Jaeller Jr*
Licensed Embalmer No. *9950*
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.**