

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034677**

**FILED VS SEP 28 1959**

Registration District No. **317** Primary Registration District No. **547** Registrar's No. **2489** STATE FILE NUMBER

RENDERED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights 17</b>		Length of stay in 1b <b>5 1/2 weeks</b>	c. CITY OR TOWN <b>University City 30,</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. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6652 Bartmer Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MARVIN DANIEL GORMAN</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>15,</b> Year <b>1959</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/1887</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Mason (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Slaughter Contg Co. St. James, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Finley Gorman</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Rose</b>		14. NAME OF HUSBAND OR WIFE <b>Flossie I. Gorman</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>497-07-0357</b>	17. INFORMANT <b>Mrs. Marvin D. Gorman 6652 Bartmer</b>	Address <b>(30)</b>
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18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Schloccia Septicemia</b> <b>Sallowig - Prostectomy</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.	Month, Day, Year <b>9-20-59</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **8-20-59** to **9/15/59** and last saw him alive on **9/15/59**  
Death occurred at **11:45** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <b>James P. Kelly M.D.</b>	22b. ADDRESS <b>730 Had.</b>	22c. DATE SIGNED <b>9/17-59</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/18/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>9-18-59</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Pierce J. Reilly  
730 Hodiament Ave.  
PA 1 5187  
(no hours Wed.)

Dr. John E. Byrne  
4660 Maryland  
PO 1 6349

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

*James E. Cullok*

Licensed Embalmer No. 2960

P. O. Address 6175 Palm

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.