

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037623

FILED VS NOV 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9724** STATE FILE NUMBER

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		c. CITY OR TOWN St. Louis	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3971 Delmar	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First John Middle Last Gilmore			4. DATE OF DEATH Month 10 Day 21 Year 59			
---	--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-25-99	9. AGE (last birthday) 59 YRS	IF UNDER 1 YEAR Months 9 Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	--	----------------------------------	--------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CAIRO, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	-----------------------------------	---	---

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
-----------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MRS EVELYN MINNETT BATES Address 4927
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Thrombosis		Undet.
DUE TO (b)		
DUE TO (c) 332x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Cardiovascular Disease, Arteriosclerotic Heart Disease		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 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 _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 **9-10-59** to **10-21-59** and last saw ~~her~~ **him** alive on **10-21-59**
 Death occurred at **2:00** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Sydney R. Drash (Degree or title) M. D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 10-23-59
--	--	----------------------------------

23a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	23b. DATE 10-26-59	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM	23d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
---	---------------------------	---	---

24. FUNERAL DIRECTOR A. F. WALTON ADDRESS 2707 STODDARD ST	25. DATE RECD. BY LOCAL REG. OCT 23 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 W. Taylor

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.