

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041797

FILED VS DEC 7 1959

210728

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>1 Hr. 15 Min.</b>	c. CITY OR TOWN <b>Overland</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda General Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3202 Calvert</b>

3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>Charles</b> Last <b>Erlewine</b>			4. DATE OF DEATH Month <b>11</b> - Day <b>19</b> - Year <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>11-19-59</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Newborn -</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>Ralph Wayne Erlewine</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Carole Collins</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mother - 3202 Calvert., Overland (11) Mo.</b>	

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)	<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>DUE TO <b>Prematurity</b></p> <p>DUE TO <b>Premature labor</b></p> <p><b>Placental Separation</b></p>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>773.5</b>		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	
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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.) <b>-</b>	
20c. TIME OF INJURY Hour <b>-</b> a.m. <b>-</b> Month, Day, Year <b>-</b>		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.) <b>-</b>	20f. CITY, TOWN, OR LOCATION <b>-</b>	COUNTY <b>-</b>	STATE <b>-</b>
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21. I attended the deceased from **11-19-59** to **11-19-59** and last saw her/him alive on **11-19-59**  
Death occurred at **8:30** P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>E. H. Riley M.D.</b>		22b. ADDRESS <b>4660 Maryland</b>		22c. DATE SIGNED <b>11-20-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-20-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL HILL</b>		23d. LOCATION (City, town, or county) (State) <b>OVERLAND, MO.</b>

24. FUNERAL DIRECTOR <b>EARL HILKEMAN</b>	ADDRESS <b>9709 LACKLAND</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 20 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**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 \_\_\_\_\_

*No Embalmed* Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Earl F. Hillman*

Licensed Embalmer No. 3501

P. O. Address \_\_\_\_\_

**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.