

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012610

FILED US MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3330** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	c. CITY OR TOWN E. 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 Missouri Pacific Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 552 N. 18th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL HARRISON GASTON			4. DATE OF DEATH Month Day Year March 21 1960			
5. SEX Male	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 12-7-1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 3 Days 14	IF UNDER 24 HR Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engine Foreman		10b. KIND OF BUSINESS OR INDUSTRY Alton & Southern R.R.		11. BIRTHPLACE (City and state or country) Sparta, Illinois		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Samuel P. Gaston		13b. MOTHER'S MAIDEN NAME Margaret Robins		14. NAME OF HUSBAND OR WIFE Zoa E. (Quillman) Gaston		
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. None		17. INFORMANT Address Mrs. Zoa Gaston, 552 N. 18th, E. St. Louis, Ill.		

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 3 Days
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION, ACUTE	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerosis of the Heart Disease	
DUE TO (b)	4200	
DUE TO (c)		

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
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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 Month, Day, Year 8:30 P 3-19-60	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 3-21-60 and last saw her alive on 3/21/60

21. I attended the deceased from **8:30 P 3-19-60** to **3-21-60** and last saw her alive on **3/21/60**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. C. Newman, M.D.	22b. ADDRESS Mo. Pac. Hospital 1755 SO. GRAND AVE	22c. DATE SIGNED 3-23-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-24-60	23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Gardens	23d. LOCATION (City, town, or county) (State) Belleville, Illinois
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24. GENERAL DIRECTOR ADDRESS W. M. C. E. St. Louis Ill	25. DATE RECD. BY LOCAL REG. MAR 23 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

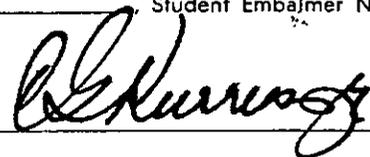
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 3162

P. O. Address E. 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.