URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-016838

FILED VS APR 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3986

STATE FILE NUMBER

NDED

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: 915 N GRAND ST LOUIS MO — Length of stay in 1b: 12 DAYS

c. CITY OR TOWN: ST LOUIS — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 3108A N TAYLOR — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle A. — Last GENTRY

4. DATE OF DEATH: Month APRIL — Day 9 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 4/21/10

9. AGE (last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHOTOGRAPHER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ST LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: HENRY GENTRY

13b. MOTHER'S MAIDEN NAME: MADGE SPENCER

14. NAME OF HUSBAND OR WIFE: ELLEN GENTRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES — (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO.: 717-16-3249

17. INFORMANT: ELLEN GENTRY — Address: 3108A N TAYLOR ST LOUIS, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ANEMIA

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): MONOCYTIC LEUKEMIA

DUE TO (c): 204.2

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): GANGRENE OF GENTEAL REGION

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. VA attended the deceased from 3/23/60, to 4/9/60 and last saw him alive on 4/9/60

Death occurred at 11:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Emerson B. Regula M.D.

22b. ADDRESS: VAH, ST LOUIS, MISSOURI

22c. DATE SIGNED: 4/9/60

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~: Burial

23b. DATE: 4/13/60

23c. NAME OF CEMETERY OR CREMATORY: Calvary

23d. LOCATION (City, town, or county) (State): St. Louis

24. FUNERAL DIRECTOR: Bruce Funeral Home — ADDRESS: 4469 Washington St. Louis 8, Mo.

25. DATE RECD. BY LOCAL REG.: APR 11 1960

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

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_____ Signed Frederick F. Sta

Signature of Student Embalmer

Licensed Embalmer No. 4599

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.