

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-016848

FILED VS. APR. 22 1960

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

2 4092

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>			Length of stay in 1b <b>5 DAYS</b>		c. CITY OR TOWN <b>ST LOUIS</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>VETS ADMIN HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1127 WALTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle Last <b>GIPSON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/1/20</b>	9. AGE (last birthday) <b>39</b>	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) <b>Unemployed</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>OXFORD, MISS.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>ED GIPSON</b>			13b. MOTHER'S MAIDEN NAME <b>MATTIE SANDERS</b>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b> <b>WW II</b>			16. SOCIAL SECURITY NO. <b>380-26-1562</b>		17. INFORMANT <b>EDDIE GIPSON</b> Address <b>1127 WALTON ST LOUIS, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERIPHERAL VASCULAR COLLAPSE</b> DUE TO (b) <b>METASTATIC SARCOMA OF LUNG</b> DUE TO (c) <b>SARCOMA OF BACK 1991</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						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)					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 _____							
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 <b>VA 4/8/60</b> to <b>4/11/60</b> and last saw him alive on <b>4/11/60</b> Death occurred at <b>8:23 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <b>James M. Smith M.D.</b>				22b. ADDRESS <b>VAH, ST LOUIS, MISSOURI</b>			22c. DATE SIGNED <b>4/13/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>4-15-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>		
24. FUNERAL DIRECTOR <b>G. Wade Crabber</b>			ADDRESS <b>4202 Finney Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 14 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>

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

*Edward C. Foley*

Licensed Embalmer No. 4444

P. O. Address 4202

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