URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6046

-60-024520
STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis City Hosp. # 1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 3843a McRee Avenue.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)
First: WALTER
Middle:
Last: GILLESPIE

4. DATE OF DEATH: Month: June Day: 10 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11/24/1877

9. AGE (last birthday): 82

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): General Car Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Frisco R. R.

11. BIRTHPLACE (City and state or country): Pennsylvania.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Peter Gillespie

13b. MOTHER'S MAIDEN NAME: Unavailable

14. NAME OF HUSBAND OR WIFE: Catherine Gillespie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): Nil

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Catherine Gillespie, Address: 3843a McRee Avenue.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH

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

DUE TO (b): Aspiration of food

DUE TO (c): Bronchopneumonia due to Staphylococcus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 491x

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. I attended the deceased from 5/26/60, to 6/10/60 and last saw ~~her~~ him alive on 6/10/60

Death occurred at 5:17 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert J. Glass M.D.

22b. ADDRESS: 1515 Lafayette Avee

22c. DATE SIGNED: 6/12/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 6/14/60

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

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

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, Inc., 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: JUN 13 1960

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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