

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960

-60-024532

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6508

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 <u>St. Louis</u>				Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u># 1 Arundel Pl.</u>		
3. NAME OF DECEASED (Type or print) <u>Jane Gourley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/29/1884</u>		
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lehmann Mach. Co</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James Anderson</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Summerville</u>			14. NAME OF HUSBAND OR WIFE <u>W. L. Gourley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>494-24-5081</u>		17. INFORMANT <u>Mrs. Geo Anderson</u>		Address <u>5500 Delmar</u>	
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)								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		<u>cerebral hemorrhage</u>		<u>3 weeks</u>		
		DUE TO (c)		<u>cardioarteriosclerosis</u>		<u>3 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>331x</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		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 <u>NOV 57</u> to <u>25 June 60</u> and last saw her alive on <u>25 June 60</u> Death occurred at <u>7:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>James M. Wood M.D.</u>				22b. ADDRESS <u>8230 Forsythe Blvd.</u>		22c. DATE SIGNED <u>25 June 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>June 29 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Maus.</u>		23d. LOCATION (City, town, or county) <u>St. Louis Mo</u>		
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 27 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7025 ✓

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 Arnold W. Schoer

Licensed Embalmer No. 3864
P. O. Address 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.