URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-028073
STATE FILE NUMBER

FILED VS AUG 4 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7250

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MISSOURI
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) 1463 Union
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First GASTON Middle A. Last BAKER
4. DATE OF DEATH Month JULY Day 20 Year 1960
5. SEX M
6. COLOR OR RACE C
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH MAY 5-81
9. AGE (last birthday) 79
IF UNDER 1 YEAR Months 2 Days 15 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY CENTURY Elec.
11. BIRTHPLACE (City and state or country) HENDERSON KY.
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME WM BAKER
13b. MOTHER'S MAIDEN NAME WINNIE MARSHALL
14. NAME OF HUSBAND OR WIFE THELMA BOOKER BAKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. FLORENCE BOOKER Address 1463 UNION

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 420.1
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. ☐ 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 JULY 15, 1960 to JULY 20, 1960 and last saw her/him alive on JULY 20, 1960
Death occurred at 1:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE William Leckelt MD (Degree or title)
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED JUL 20 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 7-25-60
23c. NAME OF CEMETERY OR CREMATORY GREENWOOD
23d. LOCATION (City, town, or county) ST LOUIS (State) MO
24. FUNERAL DIRECTOR A F WALTON ADDRESS 2707 Stoddard
25. DATE RECD. BY LOCAL REG. JUL 20 1960
26. REGISTRAR'S SIGNATURE Earl Smith M.D. MPB.

(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 W. Claude Gordon

Signature of Student Embalmer

Licensed Embalmer No. 3489

P. O. Address 1123 N. Jay

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.