

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028348

FILED VS. JUL 18 1960 318

1003

6270

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis,</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>D. O. A.</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>716I W. Florissant Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W</b> Last <b>Gilliland</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19,</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1883</b>
9. AGE (last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
10c. PLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>William Gilliland</b>		13b. MOTHER'S MAIDEN NAME <b>Anne Crecelious</b>	
14. NAME OF HUSBAND OR WIFE <b>Josephine Gilliland</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>486 44 6637</b>		17. INFORMANT <b>Eugene Gilliland</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>Arteriosclerotic coronary art disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>420.1</b>		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 <b></b> Month, Day, Year <b></b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION <b>St. Louis</b>		20f. COUNTY <b>St. Louis</b>	
20g. STATE <b>Mo.</b>		20h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21. I attended the deceased from <b>5-4-46</b> to <b>6-19-60</b> and last saw him alive on <b>6-13-60</b>		Death occurred at <b>3:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Walter O. Gorla M.D.</b>		22b. ADDRESS <b>100 No Euclid</b>	
22c. DATE SIGNED <b>6-20-60</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>6 23 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Collier Mort. 10123 St. Charles</b>		25. DATE RECD. BY LOCAL REG. <b>June 20, 1960</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith. M.D.</b>		BY AFFIDAVIT OF	

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 Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St. Ann

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.