

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8043

-60-032563

FILED VS. AUG 22 1960

318

Primary Registration District No. 1003

Registrar's No.

STATE FILE NUMBER

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 ST. LOUIS, MISSOURI				Length of stay in 1b		c. CITY OR TOWN Tilden	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First GAYLE Middle E. Last MAGANN				4. DATE OF DEATH Month AUGUST Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/7/1887	
9. AGE (last birthday) 73		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Indipendence, Mo	
13a. FATHER'S NAME Samuel Bush				13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Merritt Magann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Merritt Magann Tilden, Ill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUSPECTED DISSECTING ABDOMINAL ANEURYSM							INTERVAL BETWEEN ONSET AND DEATH 5 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 451x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARDIOVASCULAR COLLAPSE SECONDARY TO HYPERTENSIVE CARDIOVASCULAR DISEASE WITH ARTERIOSCLEROSIS.							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 _____ 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 APRIL 9, 1930 to AUG. 12, 1960 and last saw her/him alive on AUGUST 12, 1960 Death occurred at 4:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>E. J. Amellican, M.D.</i> (Degree or title)				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 8/13/60 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-16-60	23c. NAME OF CEMETERY OR CREMATORY Caledonia		23d. LOCATION (City, town, or county) Sparta, Ill		
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd. ADDRESS				25. DATE RECD. BY LOCAL REG. AUG 15 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

James Dinkley

Licensed Embalmer No. *365*

P. O. Address *St Louis*

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.