

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014237
STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 53

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED APR 26 1961

1. PLACE OF DEATH
a. COUNTY JEFFERSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL-JOACHIM TWP. Length of stay in 1b 2 MONTHS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MT. VIEW NURSING HOME Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY ST. LOUIS
c. CITY OR TOWN AFFTON Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 7523 CHESHIRE LA. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Cora Gannon
4. DATE OF DEATH Month Day Year
4 21 1961

5. SEX F 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced
8. DATE OF BIRTH 12-29-1884 9. AGE (last birthday) 76 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JACOB SCHMIDT 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE LATE THOMAS GANNON

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 JAMES T. GANNON Address 7523 CHESHIRE LA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 WKS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____

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 2-24-1961 to 4-21-61 and last saw her alive on 4-17-61.
Death occurred at 5:05 A-m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. J. Small (Degree or title) M.D. 22b. ADDRESS Engelstad City, Mo. 22c. DATE SIGNED 4-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL (MTR) 23b. DATE 4-24-1961 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION 23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR KRIEGSHAUSER ADDRESS 4228 S. KINGS HIGH WAY 25. DATE RECD. BY LOCAL REG. 4-22-61 26. REGISTRAR'S SIGNATURE Lucie A. Fisher

APR 26 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. Stovesand

Licensed Embalmer No. 4007

P. O. Address _____

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.