SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-038580

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10160

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 26 days

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Chronic Hosp. — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 1412 N. 10th St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Homer Middle Last Gamage

4. DATE OF DEATH Month Day Year 10-29-61

5. SEX Male

6. COLOR OR RACE Col.

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 1888

9. AGE (last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Emp.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Miss.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Unk.

13b. MOTHER'S MAIDEN NAME Unk.

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Walker Address 1033 Paradise-E. St. Louis.

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) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 8-10-61

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c) 332+

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 10-13-61, to 10-29-61 and last saw her/him alive on 10-29-61

Death occurred at 9:55 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Am Huggins, M.D.

22b. ADDRESS 634 N. Grand

22c. DATE SIGNED 10-31-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11-3-61

23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR G. Wade Granberry ADDRESS 4202 Finney Ave..

25. DATE RECD. BY LOCAL REG. NOV 1 1961

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

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_____ Signed Edward A. Flynn
Signature of Student Embalmer

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.