

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

9600

-61-038590

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED OCT 26 1961

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>GASCONADE</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i>		Length of stay in 1b <i>2 days</i>	c. CITY OR TOWN <i>OWENSVILLE</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <i>RURAL ROUTE</i>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>EDWIN</i> Middle <i>HENRY</i> Last <i>GAWER</i>			4. DATE OF DEATH Month <i>OCTOBER</i> Day <i>16</i> Year <i>1961</i>		
-------------------------------------------------------------------------------------------------	--	--	-------------------------------------------------------------------------	--	--

5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8/6/1881</i>	9. AGE (last birthday) <i>80</i>	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) <i>FARMER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWN FARM</i>	11. BIRTHPLACE (City and state or country) <i>Old Woolham, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
--------------------------------------------------------------------------------------------------------------	------------------------------------------------------	----------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME <i>HENRY GAWER</i>	13b. MOTHER'S MAIDEN NAME <i>ROSA KRAMER</i>	14. NAME OF HUSBAND OR WIFE <i>CAROLINE GAWER</i>
------------------------------------------	-------------------------------------------------	------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>Harry Gawer, Successor, Mo</i>
-----------------------------------------------------------------------------------------------------------------------	-------------------------------------	----------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i>		<i>1 YEAR</i>
DUE TO (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i>		<i>10 YEARS</i>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>GENERALIZED ARTERIOSCLEROSIS</i>		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
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

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.) <i>4200</i>
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

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 *OCTOBER 9, 1961* to *OCT. 16, 1961* and last saw her/him alive on *OCTOBER 16, 1961*
Death occurred at *3:00 P.M.* _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Vermillion, M.D.</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>BARNES HOSPITAL</i>	22c. DATE SIGNED <i>10/17/61</i>
-------------------------------------------------	----------------------------------	----------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>10-19-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST. JOHN CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>Old Woolham, Mo</i>
-------------------------------------------------------------	------------------------------	------------------------------------------------------------	-------------------------------------------------------------------------

24. FUNERAL DIRECTOR <i>SCHRADER, BALLWIN, MO</i>	25. DATE RECD. BY LOCAL REG. <i>OCT 17 1961</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
------------------------------------------------------	----------------------------------------------------	------------------------------------------------------

MEMBER STUDY TAG

DATE OF EXPIRATION PERIOD YEARS MONTH

1 YEAR
TO YEARS

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 Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Ballwin,

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.