

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041658

STATE FILE NUMBER

AMENDED

Registration District No. 187 Primary Registration District No. 5704 Registrar's No. 213

FILED DEC 11 1961

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

3. NAME OF DECEASED (Type or print) First Middle Last <u>STERLING EDWARD GASH</u>			4. DATE OF DEATH Month Day Year <u>DEC. 2, 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1885</u>	9. AGE (last birthday) <u>76</u>	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) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>LINN Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM GASH</u>		13b. MOTHER'S MAIDEN NAME <u>STACY McCOLLUM</u>		14. NAME OF HUSBAND OR WIFE <u>PAULINE GASH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>LUTHER GASH, WHEELING, Mo</u>		

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)	<u>MYOCARDIAL INSUFFICIENCY</u>	<u>4 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MALNUTRITION</u>	<u>2 1/2 3 mon</u>
	DUE TO (c) <u>CHRONIC ALCOHOLISM</u>	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ to 12-2-61 and last saw him alive on 12-2-61
 Death occurred at 11:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Walter Bryan MD</u>	22b. ADDRESS <u>Wheeling, Mo.</u>	22c. DATE SIGNED <u>12-3-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-5-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LACLEDE CEM</u>	23d. LOCATION (City, town, or county) (State) <u>LACLEDE, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>WRIGHT FUNERAL HOME, BROOKFIELD, MO</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 3, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

DEC 14 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 H. Burdight

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.