

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6785 - 62-028668
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

FILED JUL 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 <u>St. Louis, Missouri</u>		Length of stay in 1b <u>lifetime</u>	c. CITY OR TOWN <u>St. Louis</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 <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5830 Walsh</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>(n.m.i.)</u> Last <u>Gilles</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3-17-1876</u>
9. AGE (last birthday) <u>86</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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert Nieden</u>	
13b. MOTHER'S MAIDEN NAME <u>Rose Mueller</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph F. Gilles (Dec.)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Richard M. Hoffman</u> Address <u>5830 Walsh</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of left bent. striat. art.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>332X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>			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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <u>Acc. No. No</u>	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 <u>6/7/62</u> to <u>7-9-62</u> and last saw her alive on <u>7-8-62</u> Death occurred at <u>6:25 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John J. Hammond M.D.</u> (Degree or title)		22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>7/9/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-11-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u> ADDRESS <u>SAM</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 10 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

Dr. John J. Hammond
634 N. Grand
JE. 1-1477

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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 *Bill C. Branson*

Licensed Embalmer No. 4764

P. O. Address St. Louis, 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.