

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029439

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2267

FILED AUG 13 1962

VS 300
Rev. 4/59

14
28120

3

4 0

5 3

6

7 1

8 0

9 4201A

10

11

12 48-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ADAMS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		Length of stay in 1b 51 DAYS	c. CITY OR TOWN QUINCY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ILLINOIS SOLDIERS & SAILORS HOME Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD F. GILMORE			4. DATE OF DEATH Month Day Year AUGUST 3RD 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-22-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 70 YEARS IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) CHICAGO, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME FREDERICK GILMORE		13b. MOTHER'S MAIDEN NAME HENRIETTA HANNAH GIRGOLETT	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Vet. Adm. Hosp. Record	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS			UNKNOWN
DUE TO (c) LUETIC ANEURYSM OF THE AORTA			UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACTIVE PULMONARY TUBERCULOSIS			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.)	
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.	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. Resided the deceased from 6-13-62 to 8-3-62 Death occurred at 7:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		XXXXXXXXXXXX	
22a. SIGNATURE Casimir Mogenis CASIMIR MOGENIS		22b. ADDRESS M.D. VET.ADM.HOSP.; JEFF.BRKS., 25, MO.	22c. DATE SIGNED 8-4-62
23a. BURIAL, CREMATION, EMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	8/7/62	Natl. Cem. Jeff. Brks.	Jeff. Brks, Mo.
24. FUNERAL DIRECTOR Rowland-Ogden Mortuary, 4106 Manchester		25. DATE RECD. BY LOCAL REG. 8-6-62	26. REGISTRAR'S SIGNATURE John B. [Signature]

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 Phillip A. Ogden
Licensed Embalmer No. 5170

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.