

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041016

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2854

DO NOT WRITE ON THIS STUB

AMENDED

**FILED OCT 18 1962**

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST.</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KOCH HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>1522a HODIAMONT</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GATCHELL</u> Last <u>GATCHELL</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>30 JULY 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>83</u>
11a. FATHER'S NAME <u>WILLIAM MOPPS</u>		11b. MOTHER'S MAIDEN NAME <u>ELIZABETH SMITH</u>	11c. NAME OF HUSBAND OR WIFE <u>LEO GATCHELL</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>Wm Mopps</u> Address <u>408 S. Pershine Ave. Muncie, Ind.</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>GANGRENE OF SMALL INTESTINE</u> DUE TO (b) <u>VOLVULUS</u> DUE TO (c) <u>PERITONEAL ADHESIONS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>HOURS</u> <u>MONTHS</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>5</u> a.m. <u>9</u> 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 <u>PARIS, ILL.</u>
21. I attended the deceased from <u>22 AUG 1962</u> to <u>OCT 2 1962</u> and last saw her/him alive on <u>OCT 1, 1962</u> Death occurred at <u>5</u> <u>9</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Virgil R. Bleish M.D.</u>	
22b. ADDRESS <u>1608 GRATTAN ST.</u>		22c. DATE SIGNED <u>3 Oct 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-6-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EDGAR CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>PARIS, ILL.</u>
24. FUNERAL DIRECTOR <u>Jos. W. Clark F.H. 1125 HODIAMONT AVE</u>		25. DATE RECD. BY LOCAL REG. <u>10-8-62</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>

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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

OCT 18 1962

**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 \_\_\_\_\_  
*M. W. Williams*

Licensed Embalmer No. 4514

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.