

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041020

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 3002

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4009

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

SHOULD READ

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ferguson</b>		Length of stay in 1b <b>WKS.</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>#4 Sandringham Lane</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3237 Copelin</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret C Gill</b>			4. DATE OF DEATH Month Day Year <b>October 16, 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <b>87</b> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Clampett</b>		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <b>Roland A. Gill</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs M Kroner 4 Sandringham Lane</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Institution &amp; Rehabilitation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Encephalomalacia</b>			<b>weeks</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>years</b>
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 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 <b>2-28-1961</b> to <b>10-16-1962</b> and last saw her alive on <b>10-16-1962</b> Death occurred at <b>12:55 PST</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert C. Clark D.O.</b>		22b. ADDRESS <b>1735 A. Florissant Rd. Florissant Mo.</b>	22c. DATE SIGNED <b>10-17-1962</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/19/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>E. J. Schnur 3125 Lafayette</b>		25. DATE RECD. BY LOCAL REG. <b>10-17-62</b>	26. REGIS. BAR'S SIGNATURE <b>John C. Murphy Md.</b>

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH

Bill - Clark Clinic - 10-18-1935 - Dr. H. L. Harrison

**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 *John D. Harrison*  
Licensed Embalmer No. 4108

P. O. Address *Harrison*

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.