

FILED FEB 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6234

#44077

318

1003

1095

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			d. STREET ADDRESS (If rural, give location) 1436 Franklin Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) MARIE		b. (Middle)	c. (Last) GIBBS		4. DATE OF DEATH (Month) (Day) (Year) February 2, 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Aug. 2, 1925	9. AGE (In years last birthday) 24	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Granville Stiltz		13b. MOTHER'S MAIDEN NAME Tina Carney		14. NAME OF HUSBAND OR WIFE Melvin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Tina Stiltz, Springfield, Ill.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 002X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/25/50 1950, to 2/2/50, 1950, that I last saw the deceased alive on 2/2/50, 1950, and that death occurred at 12:25 pm, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mrs. L. Bryan, M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 2/2/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-3-50	24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Springfield, Ill.		

DATE REC'D BY LOCAL. FEB 3 1950	REGISTRAR'S SIGNATURE Jr B Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. H ppe,	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9601

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

Student Embalmer

Signed

Elmo R. Caldwell

Licensed Embalmer No. 4077

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 this body is not embalmed, fact should be so stated above.