

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

14548
 State File No. 3645
 Registrar's No.

BIRTH NO. #104965 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5519 Vernon Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) GILL c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 20th, 1950		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH April 3, 1868	9. AGE (in years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ashley, Illinois	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME John Gill		13b. MOTHER'S MAIDEN NAME Margaret Loganard		14. NAME OF HUSBAND OR WIFE DDX	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. A. Peden 5519 Vernon Ave	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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? 332X	

I hereby certify that I attended the deceased from 10/28/49 to 4/20/50, 19, that I last saw the deceased alive on 4/20/50, and that death occurred at 12:10 PM m., from the causes and on the date stated above.

23a. SIGNATURE C. Lauren (Degree or title) U		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 4/20/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-22-50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) Centralia, Illinois	
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DATE REC'D BY LOCAL REG. APR 21 1950		REGISTRAR'S SIGNATURE J. B. Rasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

J. W. M. Bankley

Licensed Embalmer No. *36530*

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.