

FILED SEP 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26605

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 766

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY GREENE 0396 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY POLK | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOLIVAR 0841 | |
| c. LENGTH OF STAY (In this place) 5mo. 7days | | d. STREET ADDRESS (If rural, give location) 509 SOUTH SPRINGFIELD, STREET | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | |

| | | | |
|--|----------------|----------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Arthur | b. (Middle) R. | c. (Last) GIST | 4. DATE OF DEATH (Month) (Day) (Year) SEPT. 6, 1951 |
|--|----------------|----------------|--|

| | | | | | | | | |
|---------------|------------------------|--|--------------------------------|------------------------------------|------------|----------|-----------|----------|
| 5. SEX MALE 0 | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH Oct. 25, 1887 | 9. AGE (In years last birthday) 63 | 10. MONTHS | 11. DAYS | 12. HOURS | 13. MIN. |
|---------------|------------------------|--|--------------------------------|------------------------------------|------------|----------|-----------|----------|

| | | | |
|--|--|---|----------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER | 10b. KIND OF BUSINESS OR INDUSTRY BARBER | 11. BIRTHPLACE (State or foreign country) BOLIVAR, MISSOURI 0 | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|--|---|----------------------------------|

| | | |
|---------------------------------|---------------------------------------|--|
| 13a. FATHER'S NAME WILLIAM GIST | 13b. MOTHER'S MAIDEN NAME EMMA MENFEE | 14. NAME OF HUSBAND OR WIFE GLENN GIST |
|---------------------------------|---------------------------------------|--|

| | | |
|---|-------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII | 16. SOCIAL SECURITY NO. Unkn. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS VAH RECORDS, VAH, SPRINGFIELD, MOI. |
|---|-------------------------------|--|

| | | | |
|---|---|--|--|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infarctions, MEDICAL CERTIFICATION Pneumonitis, Terminal and Multiple | | INTERVAL BETWEEN ONSET AND DEATH 4201 |
| | 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 Cardiac Dilatation secondary cardiac hypertrophy and healed left ventricular infarctions. Coronary Sclerosis. | | |

| | | |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" 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) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 Vet. Adm. March 29, 1951, to Sept. 6, 1951, and that death occurred at 11:40Pm., from the causes and on the date stated above.

| | | |
|--|--------------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Dr. A. J. Rondurant</u> (Degree or title) Acting Chief Professional Services | 23b. ADDRESS <u>Springfield, Mo.</u> | 23c. DATE SIGNED <u>9/7/51</u> |
|--|--------------------------------------|--------------------------------|

| | | | |
|--|-------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>Sept 7, 1951</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Bolivar, Mo.</u> |
|--|-------------------------------|--|---|

| | | |
|--|---|---|
| DATE REC'D BY LOCAL REG. <u>9-7-51</u> | REGISTRAR'S SIGNATURE <u>W E Haulby</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alma Schmeier, Springfield, Mo.</u> |
|--|---|---|

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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

James W. Wair

Licensed Embalmer No. *4650*

P. O. Address *Springfield 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 this body is not embalmed, fact should be so stated above.