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0.48

XC 1071509
Reg # 96785

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32167

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 607 Registrar's No. 3190

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI; b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD 0370	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		d. STREET ADDRESS (If rural, give location) #2, BOX 248G	

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle) L.	c. (Last) GAAL	4. DATE OF DEATH (Month) (Day) (Year) SEPT 19, 1951
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5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-4-91	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER	10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) CHICAGO, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME JULIA (UNKNOWN)	14. NAME OF HUSBAND OR WIFE MABEL GAAL
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 497051412	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF BRKS, MO.	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION GLOBLASTOMA, MULTIFORME		INTERVAL BETWEEN ONSET AND DEATH APPROX 3 MO.
	ANTECEDENT CAUSES DUE TO (b) CRANIOTOMY		26 HOURS
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		193X

19a. DATE OF OPERATION 9-18-51	19b. MAJOR FINDINGS OF OPERATION GLOBLASTOMA; MULTIFORME	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? D
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22. I hereby certify that I attended the deceased from 9-14-51, 19, to 9-19-51, and that death occurred at 10:25 p. m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) E. C. O'Brien, M.D., VET ADM HOSP, JEFF BRKS, MO.	23b. ADDRESS	23c. DATE SIGNED 9-19-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Rail	24b. DATE 9/20/51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 9-20-51	REGISTRAR'S SIGNATURE Herbert G. Donohue MD.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffmeister U&L Co. 7814 S. Bdwy City II
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2507 - 6 AM
2507 - 7 AM
2507 8 2 AM

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.....

Levin E. Hoffert

Licensed Embalmer No.

3871

P. O. Address.....

7814 8th Bross

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.