

FILED SEP 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32168

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 3133

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY OR TOWN Manchester | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 73 TOWN CREVE COEUR. | |
| c. LENGTH OF STAY (in this place) 1R | | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 4, 1951 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nursing Home | | d. STREET ADDRESS (If rural, give location) 0 | |

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|--|-------------------------------|---|--|--|------------------------|------------------------------|-----------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Gaffney c. (Last) Gaffney | | | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 4, 1951 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) UNKNOWN | 8. DATE OF BIRTH UNKNOWN | 9. AGE (In years last birthday) About 70 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) UNKNOWN - 9 | | 12. CITIZEN OF WHAT COUNTRY? | | |

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| 13a. FATHER'S NAME UNKNOWN | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE UNKNOWN - |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Pine Crest Nursing Home, Ballwin, 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac dilatation | | | 1 day |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis | | | 2 yrs 5 yrs |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 4221 | | |

| | | |
|---|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | 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 **8/5**, 19**51**, to **9/4**, 19**51**, that I last saw the deceased alive on **9/3**, 19**51**, and that death occurred at **10:55 P.m.**, from the causes and on the date stated above.

| | | |
|--|-----------------------------------|--|
| 23a. SIGNATURE R. A. Thealish (Degree or title) | 23b. ADDRESS Lakewood, Mo. | 23c. DATE SIGNED 9/6/51 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 9-7-51 | 24c. NAME OF CEMETERY OR CREMATORY ANATOMICAL |
| 24d. LOCATION (City, town, or county) (State) Washington University | | |

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|---|---|--|
| DATE REC'D BY LOCAL REG. 9-12-51 | REGISTRAR'S SIGNATURE Robert P. Tomke MD | 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS |
|---|---|--|

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..... *Ben Hoffman*

Licensed Embalmer No. *4366*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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