

FILED NOV 3 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35056  
Registrar's No. 8008

BIRTH NO. \_\_\_\_\_ 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 St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carsonville 4190	
c. LENGTH OF STAY (In this place) 1 Day		d. STREET ADDRESS (If rural, give location) 8920 Natural Bridge Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital			

3. NAME OF DECEASED (Type or Print) Charles H. Gaines			4. DATE OF DEATH (Month) (Day) (Year) Sept. 8th, 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 16th, 1869		9. AGE (In years last birthday) 82

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Yallville, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Wesley Gaines		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Late Catherine Gaines			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leslie W. Stedman, 8920 Natural Bridge Blvd			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-Vascular disease  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) —  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility				INTERVAL BETWEEN ONSET AND DEATH —	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	
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22. I hereby certify that I attended the deceased from Nov. 19, 1949 to Sept. 8, 1951, that I last saw the deceased alive on Sept. 7, 1951, and that death occurred at 4:12A m., from the causes and on the date stated above.

23a. SIGNATURE Albert Wall		(Degree or title) M.D.		23b. ADDRESS 5322 Helen Ave.		23c. DATE SIGNED 9/8/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/10/51		24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
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DATE REC'D BY LOCAL REG. SEP 10 1951		REGISTRAR'S SIGNATURE C. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Natural Bridge Blvd.			
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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..... *Ralph C. Linders*

Licensed Embalmer No. *4275*

P. O. Address *St. Louis, 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.