

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35061

State File No. 9330

Registrar's No. 9330

BIRTH NO. 71928-51 REG. DIST. NO. 319 PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) Madison 8120	
c. LENGTH OF STAY (in this place) 4 hrs		STREET ADDRESS (If rural, give location) 1035 Biwell	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary			
3. NAME OF DECEASED a. (First) Baby		b. (Middle) Gary	
c. (Last) Gary		4. DATE OF DEATH (Month) (Day) (Year) 9-30-51	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 9-30-51
9. AGE (In years) last birthday 4		10. USUAL OCCUPATION (If dead of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) 0
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Britt Gary Jr	13b. MOTHER'S MAIDEN NAME Minnie Lee Cooper	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Minnie Lee Gary	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 28 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X
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22. I hereby certify that I attended the deceased from Sept 30, 1951, to Sept 30, 1951 that I last saw the deceased alive on Sept 30 (3 PM) 1951, and that death occurred at 7 P. m., from the causes and on the date stated above.

23a. SIGNATURE Clifford A. Hancock MD	(Degree or title)	23b. ADDRESS 360 A & 15th E. St. La.	23c. DATE SIGNED 10-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE OCT 23 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Burial	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. OCT 23 1951	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
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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.....
..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.

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.