

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32749**

DECEASED **1 1952**

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **8569**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8569	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) _____			
b. CITY (If outside corporate limits, write RURAL and give town or town St. Louis, Missouri)		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2239			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 913 Soulard			
3. NAME OF DECEASED (Type or Print) a. (First) Hester		b. (Middle) JANE		c. (Last) Bishop		4. DATE OF DEATH (Month) (Day) (Year) September 11, 1952	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 8-22-76	
9. AGE (in years last birthday) 76		IF UNDER 1 YEAR Months _____		IF UNDER 1 HR. Hours _____		Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Gaston		13b. MOTHER'S MAIDEN NAME Elizabeth Whitney		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Medical Record PATRICK BISHOP		ADDRESS 913 SOULARD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA - thrombosis							
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Cerebral Arteriosclerosis					
		DUE TO (c) Arteriosclerosis & emphysema					
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., to 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? 331X 3311			
22. I hereby certify that I attended the deceased from 8-25, 1952 , to 9-11, 1952 , that I last saw the deceased alive on 9-11, 1952 , and that death occurred at 11:35A m., from the causes and on the date stated above.							
23a. SIGNATURE John W. Wallace M.D. (Degree or title)				23b. ADDRESS 1515 Lafayette Ave.		23c. DATE SIGNED 9-11-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE SEPT 15 1952		24c. NAME OF CEMETERY OR CREMATORY NEW ST MARCUS CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	
DATE REC'D BY LOCAL REG. SEP 12 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kates 2906 Gravois Ave.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 Homer C. Dill

Licensed-Embalmer No. 4347

P. O. Address 3906 Grand Ave

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.