

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3336**
0495

FILED FEB 2 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Andrain	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Mexico	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 1027 Harwood ave. 00431	

3. NAME OF DECEASED (Type or Print)	a. (First) GLEA	b. (Middle) BONNIE	c. (Last) TATE	4. DATE OF DEATH (Month) (Day) (Year) January 15, 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10-13-1905	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Mo. 0	12. COUNTRY OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Nael McCowan	13b. MOTHER'S MAIDEN NAME Ruby Appleman	14. NAME OF HUSBAND OR WIFE Forest Tate
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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 Forest Tate, Mexico, 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 UNKNOWN
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GLIOBLASTOMA, RIGHT FRONTAL LOBE		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 1-14-54	19b. MAJOR FINDINGS OF OPERATION. RIGHT CRANIOTOMY FOR REMOVAL OF GLIOBLASTOMA	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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 193X
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22. I hereby certify that I attended the deceased from **1-14-54**, to **1-15-**, **1954**, that I last saw the deceased alive on **1-15-**, **1954**, and that death occurred at **10:25 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Bradley M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 1-16-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-16-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Mexico, Mo.
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DATE REC'D BY LOCAL REG. JAN 18 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Arnold F. Home, Mexico, Mo.	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.....
Signature of Student Embalmer

Signed *[Handwritten Signature]*.....

Licensed Embalmer No. *[Handwritten Number]*.....

P. O. Address *[Handwritten Address]*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.