

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24118**

BIRTH NO. **45744-54** REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **144**

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Ann	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital		d. STREET ADDRESS (If rural, give location) 10408 St. Charles Rd.	

3. NAME OF DECEASED (Type or Print) a. (First) Gerard b. (Middle) Giljum c. (Last) Giljum			4. DATE OF DEATH (Month) (Day) (Year) July, 12, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH July 11 1954		9. AGE (In years last birthday) 1		10. UNDER 1 YEAR 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) #####		10b. KIND OF BUSINESS OR INDUSTRY #####		11. BIRTHPLACE (City and State or Foreign Country) St. Charles Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME George P. Giljum		13b. MOTHER'S MAIDEN NAME Martha Jane Hagan		14. NAME OF HUSBAND OR WIFE #####	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (a. no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George P. Giljum 10408 St. Chas. Rd	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fetal Atalaxias ANTECEDENT CAUSES Prematurity Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH app 24 hours app 24 hours	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7625		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?		
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22. I hereby certify that I attended the deceased from **July 11, 1954** to **July 12, 1954**, that I last saw the deceased alive on **July 12, 1954**, and that death occurred at **5:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. McNamee, MD		23b. ADDRESS 10300 St. Charles Rd. St. Louis, Mo.		23c. DATE SIGNED July 13 1954	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 13 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) St. Louis Mo.	
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE July 13 1954		REG. 284-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Collier Mortuary 10123 St. Chas. Rd	
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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 Sheldon Collins

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Sheldon Collins

Licensed Embalmer No. 3382

P. O. Address 10123 St. Char. Rd.

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.