

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42382

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10723**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Macoupin</b>	
b. CITY (If outside corporate limits, write RURAL and give ORN TOWN <b>St. Louis, Missouri</b> )		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Carlinville</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>NATHALIE</b> b. (Middle) <b>ELIZABETH</b> c. (Last) <b>GAIEN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 23, 1954</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Feb. 29, 1940</b>
9. AGE (In years last birthday) <b>14</b>		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Cairo Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Albert Galen</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Fobel</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give dates of service) <b>NY</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Albert Galen Carlinville Ill.</b> ADDRESS
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, asthenia, etc. It means the disease, injury, or complication which caused death.			INTERVAL BETWEEN ONSET AND DEATH. <b>3 weeks</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute lymphocytic leukemia</b>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>2044</b>	
22. I hereby certify that I attended the deceased from <b>11-15</b> , 19 <b>54</b> , to <b>11-23</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>11-23</b> , 19 <b>54</b> , and that death occurred at <b>10:30 am.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>C. J. Vermillion, M.D.</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>11-23-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11-24-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	24d. LOCATION (City, town, or county) (State) <b>Carlinville Ill.</b>
DATE REC'D BY LOCAL REG. <b>NOV 24 1954</b>	REGISTRAR'S SIGNATURE <b>C. J. Vermillion</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>A.H. Hoppe</b> ADDRESS <b>4704 Washington Ave.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul A. Mache*.....

Licensed Embalmer No. *470*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.