

FILED MAY 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16646  
Registrar's No. 4101

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4132 Glasgow		d. STREET ADDRESS 4132 Glasgow	

3. NAME OF DECEASED (Type or Print) a. (First) George	b. (Middle)	c. (Last) Gillespie	4. DATE OF DEATH (Month) (Day) (Year) May 7, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 10, 1884	9. AGE (In years last birthday) 71	10. UNDER 1 YEAR Month Days	11. UNDER 1 Mth. Hours Mts.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Die Grinder	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Gillespie	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Carrie Gillespie
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Hazel Clement, 4123 Glasgow	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 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) during 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. Chl. myocarditis		10 yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Biopsy Bronchovascular Ca	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 162X
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22. I hereby certify that I attended the deceased from Feb 27, 1955 to 5-7-1955, that I last saw the deceased alive on May 2, 1955 and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Nels S. Ruett M.D.	23b. ADDRESS 2739 N. Grand	23c. DATE SIGNED 5-9-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/10/55	24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. MAY 9 1955	REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S. P.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 No. Grand Bl.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Killbe Trust Co.*

**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 *Stanley D. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *St. L.*

**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.