

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31863

State File No.

FILED OCT 8 - 1955

BIRTH NO. 25816-55 REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 590 Registrar's No. 2229

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN BERKLEY
c. LENGTH OF STAY (in this place) 6 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION 6339 Graham Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI b. COUNTY St. Louis
c. CITY OR TOWN BERKLEY 409
d. Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) 6339 GRAHAM RD.

3. NAME OF DECEASED (Type or Print)
a. (First) Michael b. (Middle) Gleason c. (Last) Gleason
4. DATE OF DEATH (Month) (Day) (Year) 9-25-55

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH April 2, 1905 9. AGE (In years last birthday) 6 IF UNDER 1 YEAR Months 6 IF UNDER 12 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child 10b. KIND OF BUSINESS OR INDUSTRY child 11. BIRTHPLACE (City and State or Foreign Country) St. Louis - Co 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Gleason 13b. MOTHER'S MAIDEN NAME MARGARET R. RENSHAW 14. NAME OF HUSBAND OR WIFE None

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. _____ 17. INFORMANT'S SIGNATURE OR NAME John Gleason ADDRESS 6339 GRAHAM RD.

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration - acidosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diarrhea
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
few hours
3-4 days

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 5710 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9-25, 1955 to 9-25, 1955, that I last saw the deceased alive on 9-25, 1955, and that death occurred at 9:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Raymond J. LaSiere MD 23b. ADDRESS 35 N. Central Ave - Clayton 5, 23c. DATE SIGNED 9-26-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Sept 26-1955 24c. NAME OF CEMETERY OR CREMATORY Calvary 24d. LOCATION (City, town, or county) (State) St. Louis

DATE REC'D BY LOCAL REG. 9-26-55 REGISTRAR'S SIGNATURE Herbert K. Donaldson 25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's ADDRESS 2849 N. Euclid

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

2000-1.7

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.....
Albert Mayfield

Licensed Embalmer No. *307*

P. O. Address *St Louis*

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.