

FILED MAY 8 1956

STANDARD CERTIFICATE OF DEATH

14576  
State File No. 1003  
Registrar's No. 3903

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

|   |                        |  |  |
|---|------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN ST. LOUIS, MISSOURI |                        | c. CITY OR TOWN St. Louis,   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.                                 |                        | e. STREET ADDRESS (If rural, give location)<br>1427 Missouri Ave. 22570  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) JOSEPH b. (Middle) Bryan c. (Last) GANDY          |                        | 4. DATE OF DEATH (Month) (Day) (Year)<br>APRIL 19, 1956  |  |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married   | 8. DATE OF BIRTH Feb. 2, 1888  |
| 9. AGE (In years last birthday) 68  |                        | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown                   | 11. BIRTHPLACE (City and State or Foreign Country) Tenn.   |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |                        |  |  |

|                                     |   |                                  |
|-------------------------------------|---|----------------------------------|
| 13a. FATHER'S NAME Charles S. Gandy | 13b. MOTHER'S MAIDEN NAME Sarah Ida Patrick | 14. NAME OF HUSBAND OR WIFE Nil. |
|-------------------------------------|---|----------------------------------|

|  |                                 |   |
|--|---------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. # 1 | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Hospital Records, 1515 Lafayette |
|--|---------------------------------|---|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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  |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia due to aspiration   |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Pneumococcal meningitis<br>DUE TO (c) Pneumococcal pneumonia |  |                                  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |                                  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 340-1 | 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) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                      |

22. I hereby certify that I attended the deceased from 3/11, 1956, to 4/19, 1956, that I last saw the deceased alive on 4/19, 1956, and that death occurred at 4:00 AM, from the causes and on the date stated above.

|   |                                  |                           |
|---|----------------------------------|---------------------------|
| 23a. SIGNATURE (Degree or title) [Signature] M.D. | 23b. ADDRESS 1515 LAFAYETTE AVE. | 23c. DATE SIGNED 4/19/56. |
|---|----------------------------------|---------------------------|

|   |                   |  |  |
|---|-------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 4-19-56 | 24c. NAME OF CEMETERY OR CREMATORY Local | 24d. LOCATION (City, town, or county) (State) Memphis, Tenn. |
|---|-------------------|--|--|

|                          |   |   |
|--------------------------|---|---|
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington, |
|--------------------------|---|---|

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 *Elton H. Remel*.....

Licensed Embalmer No. *42*.....

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.