

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1956

State File No. **24969**

318

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Registrar's No. **5991**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 5991	
1. PLACE OF DEATH a. COUNTY 2504 Belt				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2504 Belt (Home)				e. STREET ADDRESS (If rural, give location) 2504 Belt Ave. 2067			
3. NAME OF DECEASED (Type or Print), a. (First) Lorena		b. (Middle) _____		c. (Last) Gaw		4. DATE OF DEATH (Month) (Day) (Year) 6 22 56	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 4, 1896	
9. AGE (in years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Graves		13b. MOTHER'S MAIDEN NAME Margaret Thomas		14. NAME OF HUSBAND OR WIFE William Gaw			
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Norma Gaw 3565a St. Louis Ave			
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) Cerebral apoplexy ANTECEDENT CAUSES Hypertension 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.				INTERVAL BETWEEN ONSET AND DEATH 1 day	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) M		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 334x			
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? _____			
22. I hereby certify that I attended the deceased from 10/23, 1955 , to 6/23, 1956 , that I last saw the deceased alive on 6/23, 1956 , and that death occurred at 10 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Dr. T. M. Chouteau				23b. ADDRESS 3136 Chouteau		23c. DATE SIGNED 6/25/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-25-56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Missouri	
DATE REC'D BY LOCAL REG. JUN 25 1956		REGISTRAR'S SIGNATURE Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G. W. Roberts Undertaking Co. 1416 Taylor			

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 *James A. Carter*.....
Licensed Embalmer No. *46*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.