

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33128

FILED NOV 5 - 1956

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 343

300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u> <u>Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Hosp</u> Length of stay in lb <u>6 days</u>		d. STREET ADDRESS (If outside, give location) <u>Jesse James Hotel</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alonzo</u> Middle <u>GAY</u> Last <u>GAY</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>	9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>Jamestown, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James GAY</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Estel E. Gay</u>		Address <u>St. Joseph, Mo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease &amp; Congestive Failure</u> DUE TO (b) <u>Chronic Lymphatic Leukemia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>10-24-56</u> to <u>10-30-56</u> and last saw her alive on <u>10-30-56</u> Death occurred at <u>11:55</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James J. Ostrowski M.D.</u>		22b. ADDRESS <u>Ellis Fischel Hosp</u>	
22c. DATE SIGNED <u>10-31-56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-2-56</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Helena Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Helena, Mo.</u>	
24. FUNERAL DIRECTOR <u>Parker Funeral Service</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 31, 1956</u>	
ADDRESS <u>Columbia, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *J.P. S. Whitfield*.....

Licensed Embalmer No... *38*

P. O. Address *Calumb*.....

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.