

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43060**

FILED DEC 18 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10724**

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

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>                |                               | c. LENGTH OF STAY (in this place) _____   |  |
| c. CITY OR TOWN <b>St. Louis</b>   |                               | 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 <b>956 Hamilton</b>  |                               | e. STREET ADDRESS (If rural, give location) <b>6105 Virginia</b>  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>HAZEL</b> b. (Middle) <b>IRMA</b> c. (Last) <b>GAYNOR</b>  |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>11 22 56</b>   |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   | 8. DATE OF BIRTH <b>6-18-1920</b>        |
| 9. AGE (In years last birthday) <b>36</b>  |                               | 10. UNDER 1 YEAR Months _____ Days _____  | 11. UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>Bunker, Missouri</b>                                   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME <b>George Byerly</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Emma Henry</b>   |  |
| 14. NAME OF HUSBAND OR WIFE <b>Joseph Gaynor</b>   |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>                |  |
| 16. SOCIAL SECURITY NO. _____  |                               | 17. INFORMANT'S SIGNATURE OR NAME <b>Joseph Gaynor, 6105 Virginia</b>   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sarcoma rt. Deltoid Muscle</b><br>ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b><br>DUE TO (b) <b>Sarcoma, Rt. deltoid</b><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 WEEK</b><br><b>2 yrs.</b> |  |
|--|--|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION _____                          |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>197x</b>                      |  |
| 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 **San**, 19**56**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on **11-22-56**, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. SIGNATURE <b>Key in Leo Stehlo</b> (Degree or title) _____              |  | 23b. ADDRESS <b>3720 Washington</b>                           |  | 23c. DATE SIGNED <b>11-24-56</b>                             |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>                     |  | 24b. DATE <b>11-26-1956</b>                                   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b> |  |
| 24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin F.H., Inc.</b> |  | ADDRESS <b>2301 Lafayette</b>                                |  |

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**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.....  
*L. P. Cooper*

Licensed Embalmer No. *363*

P. O. Address *2317 Leff*

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.