

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10300**
Registrar's No. **2502**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 20 yrs		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		e. STREET ADDRESS (If rural, give location)	
5056 St. Louis Ave.		5056 St. Louis Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Dollie b. (Middle) Ann c. (Last) Gilstrap			4. DATE OF DEATH (Month) (Day) (Year) 3-11-1957	
---	--	--	--	--

5. SEX female 3		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH 7-4-1884		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
---------------------------	--	----------------------------------	--	--	--	-------------------------------------	--	--	--	---	--	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house mother		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) Holygrove, Ark. / USA				12. CITIZEN OF WHAT COUNTRY? USA	
--	--	--	--	--	--	--	--	--	--

13a. FATHER'S NAME Elex Simpson		13b. MOTHER'S MAIDEN NAME Emiline Haynes		14. NAME OF HUSBAND OR WIFE William Henry Gilstrap			
---	--	--	--	--	--	--	--

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 Francis Reedy 5056 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Arteriosclerotic changes					
		ANTECEDENT CAUSES		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
				DUE TO (b) Renal stenosis, Hypertension					
				DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					

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) 2	
--	--	--	--	--	--

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 **2-15 1957** to **3-11 1957**, that I last saw the deceased alive on **3-11 1957**, and that death occurred at **2 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 3000 = Easton		23c. DATE SIGNED 3-13-57	
--	--	--------------------------------------	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) removed		24b. DATE 3-18-1957		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo	
---	--	-------------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. MAR 13 '57		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dunn Funeral HOME 215 So. Jeff.	
---	--	---	--	--	--

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

APR 12 1957

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 *Arthur L. Helliard*

Licensed Embalmer No. *4221*

P. O. Address *5516 Maple*

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.