

FILED MAY - 8 1957

STANDARD CERTIFICATE OF DEATH

14714

STATE FILE NUMBER

318

1003

4011

Registration District No. Primary Registration District No.

Registrar's No.

Health & Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally 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				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4435 Minnesota			Length of stay in 1b		d. STREET ADDRESS 4435 Minnesota		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JOHN QUINCY PRIMM GILCHRIST				4. DATE OF DEATH Month Day Year APRIL 24 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1901		9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Lincoln, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Gilchrist				14. MOTHER'S MAIDEN NAME Emily Davidson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 486 16 2074		17. INFORMANT Address John M. Gilchrist, 4435 Minnesota					
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>Coronary Vascular Heart disease</u> DUE TO (b) _____ DUE TO (c) <u>Chronic Nephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>592X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3</u> <u>Oct 14 51</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 Month, Day, Year 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>Oct 25-57</u> to <u>April 24-57</u> and last saw her/him alive on <u>April 23-57</u> . Death occurred at <u>11 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>H. J. Moore M.D.</u> (Degree or title)				22b. ADDRESS <u>912-5018</u>			22c. DATE SIGNED <u>4-26-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-27-1957	23c. NAME OF CEMETERY OR WHERE Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri				
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette				25. DATE RECD. BY LOCAL REG. APR 26 '57		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</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 *A. G. Farris*

Licensed Embalmer No. *338*

P. O. Address *A. Farris*

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.