

Admitted to hospital 7/26/57 at 7:40 PM
 All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29474
 STATE FILE NUMBER
 Registrar's No. **7070**

FILED AUG 26 1957

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>RANDOLPH</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Chester</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>32 R.F.D. #2</u>	
Length of stay in lb <u>2 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORA L. GILBERT</u>			4. DATE OF DEATH Month Day Year <u>July 28 1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</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>MAY 20, 1916</u>
9. AGE (In years last birthday) <u>41</u>		10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ANTI-QUEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>shoe factory</u>	11. BIRTHPLACE (City and state or country) <u>RADDE, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>George Herman Ball</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY Shemonie</u>		14. NAME OF HUSBAND OR WIFE <u>Jimmie & Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No NONE</u>		16. SOCIAL SECURITY NO. <u>344-01-0513</u>	
17. INFORMANT <u>Jimmie Gilbert</u>		Address <u>Chester, Ill</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>Respiratory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastatic Breast Carcinoma</u>			<u>3 to 4 wks</u>
DUE TO (c) <u>Purpura Secondary to above.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>170x</u>	
20c. TIME OF INJURY Hour Month, Day, Year o.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>7/26/57</u> to <u>7/28/57</u> and last saw her alive on <u>7/28/57</u> Death occurred at <u>4 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold L. Braunhain, M.D.</u>		22b. ADDRESS <u>216 S. Kingshighway St. Louis, Mo</u>	
22c. DATE SIGNED <u>7/29/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>St. Mary's</u>		23b. DATE <u>7-30-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>Chester Ill.</u>	
24. FUNERAL DIRECTOR <u>Oscar Schroeder</u>		ADDRESS <u>Chester Ill</u>	
25. DATE RECD. BY LOCAL REG. <u>JUL 30 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

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 *Irma Cronoff*

Licensed Embalmer No. *4356*

P. O. Address *St. Louis, Mo.*

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.