

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37459

STATE FILE NUMBER

10590

FILED NOV 15 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 10590

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> , b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> , Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> , Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 3943 Delor St.</u> , Length of stay in 1b		d. STREET ADDRESS <u>15 3943 Delor St.</u> , (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle Last <u>Gilfoyle</u>			4. DATE OF DEATH <u>November 7, 1957</u> Month Day Year		
5. SEX <u>Male</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>September 18, 1903</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Strickland Printing Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael Gilfoyle</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Dugan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-09-7556</u>		17. INFORMANT Address <u>Mrs. Vera Gilfoyle, (Wife) 3943 Delor St.</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>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DIS.</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>					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.)			
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>MAR 8, 1951</u> to <u>NOV. 7, 1957</u> and last saw <del>him</del> <u>him</u> alive on <u>NOV 7, 1957</u> . Death occurred at <u>7:45 A.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 Sedlman, MD</u>		22b. ADDRESS <u>539 N. Grand, St. Louis, Mo</u>		22c. DATE SIGNED <u>11/7/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal.</u>		23b. DATE <u>11/9/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillsboro, Illinois,</u>	
23d. LOCATION (City, town, of county) (State)		24. FUNERAL DIRECTOR ADDRESS <u>Gehken-Benz Mortuary, 2842 Meramec St., St. Louis, 18, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 7 '57</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>					

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 II must be causally related. Coroner cannot certify to a death due to natural causes.

(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 me, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Joe S Benz

Licensed Embalmer No. 4249  
2842 Meramec  
P. O. Address St., Louis,

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.