

pt. Health,
... & Welfare
S. Public
with Service

V. S. 300
ev. 1-57

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 10 1957

41816

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11370**

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 b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 2376 904 RUTGER	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES DANIEL GAIN			4. DATE OF DEATH Month Day Year OCT. 29, 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ????
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) 9 UNKNOWN
13a. FATHER'S NAME ????		13b. MOTHER'S MAIDEN NAME ??????	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NONE		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address ST. LOUIS CITY HOSP. #1.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STAPHYLOCOCCAL PNEUMONIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) BRONCHOGENIC CARCINOMA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 162x			INTERVAL BETWEEN ONSET AND DEATH
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 <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 10/2/57 to 10/29/57 and last saw her alive on 10/29/57 Death occurred at 4:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Donald W. Gresham, Jr., M.D.</i>		22b. ADDRESS 1515 LABAYETTE AVE.	22c. DATE SIGNED 11 10/29/57
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-30-57	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service 1104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. NOV 27 57	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i> m86

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

15/5/52

15/5/52

Licensed Embalmer No.

P. O. Address

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.