

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002800

STATE FILE NUMBER

FILED JAN 28 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

364

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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		Length of stay in lb	d. STREET ADDRESS 2059 5927 Maple (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gus Middle Last Carey		4. DATE OF DEATH Month Day Year January 6, 1959	
5. SEX Male o	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 7 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1891 67
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		Apartment Houses	Indiana / U.S.
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE unknown
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. +92-10-2820	17. INFORMANT Miss Bearman Address Missouri Welfare Office
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>420.0</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 _____ and last saw her/him alive on _____ Death occurred at _____ to _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Patrick C. Taylor, Coroner</i> (Type or title)		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>1/12/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>1/13/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>
24. FUNERAL DIRECTOR <i>Morrell Mortuary</i> ADDRESS <i>3710 North Grand</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 12 59</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith Mo</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Loren E Pence* .....  
Licensed Embalmer No. *4094* .....  
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.