

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015011

STATE FILE NUMBER

2 4199

FILED MAY 12 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

300  
1-57

74

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|  |                                      |   |   |   |   |
|--|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                      |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Saint Louis</u>  |                                      | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Saint Louis</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |
| 3. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Enr. Homer G. Phillips</u>   |                                      | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br><u>2735 Delmar Blvd.</u>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Annie</u> Middle <u>Ma</u> Last <u>Gilliam</u>  |                                      |   | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>25</u> Year <u>1959</u>   |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>3 Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-12-1917</u>  | 9. AGE (In years last birthday)<br><u>42</u> IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>13</u> IF UNDER 24 HRS.<br>Hours _____ Min. _____ |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13a. FATHER'S NAME<br><u>Jim Wheeler</u>   |                                      | 13b. MOTHER'S MAIDEN NAME<br><u>Annie Wright</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Martin Gilliam</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                      | 16. SOCIAL SECURITY NO.<br><u>?</u>   | 17. INFORMANT<br><u>Martin Gilliam</u> Address <u>2735 Delmar Blvd.</u>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>                                      |                                      |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                                      | DUE TO (b) _____  |   |   | 331X  |
|  |                                      | DUE TO (c) _____  |   |   |   |
| 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?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour _____ 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 _____ to _____ and last saw her alive on _____<br>Death occurred at _____ 'm on the date stated above; and to the best of my knowledge, from the causes stated. |                                      |   |   |   |   |
| 21a. SIGNATURE (Degree or title)<br><u>Darick Taylor Carous</u>  |                                      |   | 21b. ADDRESS<br><u>1300 Clark</u>   |   | 21c. DATE SIGNED<br><u>4-29-59</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |                                      | 23b. DATE<br><u>5-1-1959</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>National, Jefferson Bks.</u>   |   | 23d. LOCATION (City, town, or county) (State)<br><u>Jefferson, Bks. Missouri</u>                  |
| 24. FUNERAL DIRECTOR<br><u>Ellis Funeral Home</u> ADDRESS <u>2820 Stoddard St.</u>   |                                      |   | 25. DATE RECD. BY LOCAL REG.<br><u>APR 29 59</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith, M.D.</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 *Frederic E. Culkin* .....

Licensed Embalmer No. *4198* .....  
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.