

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018546
STATE FILE NUMBER

JUN 15 1959 Registration District No. 201 Primary Registration District No. 3048 Registrar's No. 182

1. PLACE OF DEATH a. COUNTY <u>Hodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lentz</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Stanberry</u> 0380 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		Length of stay in lb <u>5 Day</u>	d. STREET ADDRESS (If outside of location) <u>High St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Winfred T.</u> Middle <u>Gay</u> Last <u>Gay</u>			4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1959</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Dec. 27, 1984</u>	9. AGE (In years, last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Painting Houses</u>	11. BIRTHPLACE (City and state and country) <u>Lentz County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Daniel Brooker Gay</u>	13b. MOTHER'S MAIDEN NAME <u>Martha ANN Robertson</u>	14. NAME OF HUSBAND OR WIFE <u>Olive S Gay</u>
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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>490-079863</u>	17. INFORMANT <u>Ma Olive S Gay</u>	Address <u>Stanberry Mo</u>
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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>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive C U R disease</u>	
	DUE TO (c) <u>with decompensation</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	

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 <u>Maryville Mo</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from 6/7/59 to 6/12/59 and last saw ^{him} alive on 6/12/59
Death occurred at 3:00 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Maryville Mo</u>	22c. DATE SIGNED <u>6/13/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>June 14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Stanberry Mo</u>
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24. FUNERAL DIRECTOR <u>Phillips Mortuary</u>	ADDRESS <u>Stanberry</u>	25. DATE RECD. BY LOCAL REG. <u>6-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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1-57

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6476 8 WIF

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 *Harold G. Hoalred*

Licensed Embalmer No. *4609*

P. O. Address. *King B. Lynn 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.