

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032970

FILED VS OCT 6 1959/81

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 33

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY LINCOLN				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Elsberry		Length of stay in lb 1 day		c. CITY OR TOWN Troy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LaDelle Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Gen'l Del.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLYDE Middle ORAN Last GILL				4. DATE OF DEATH Month September Day 9 Year 1959				
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> unknown		8. DATE OF BIRTH May 24, 1875	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Ret. Drug Store		11. BIRTHPLACE (City and state or country) Patterson, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Monroe Gill			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. 490-28-9102A		17. INFORMANT 4792 Wallace St. Louis Mrs. Joe Palazzolo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the larynx DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year								
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 Sept 8, 1959 to Sept 9, 1959 and last saw him alive on Sept 9, 1959 Death occurred at 3:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Robert M. Shultz (Degree or title)				22b. ADDRESS Elsberry Mo.		22c. DATE SIGNED 9-10-59 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-10-59	23c. NAME OF CEMETERY OR CREMATORY State Anatomical Board St. Louis Univ. Med. School		23d. LOCATION (City, town, or county) St. Louis, Missouri				
24. FUNERAL DIRECTOR O. C. Ricks		ADDRESS Elsberry, Mo.		25. DATE RECD. BY LOCAL REG. 9-10-1959	26. REGISTRAR'S SIGNATURE Mrs. Clarence Kientz			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision. *NOT EMBALMED,*

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. *4012*

P. O. Address *Elsherry,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.