

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008226

FILED VS MAR 11 1960

2 1956

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOU	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY Hosp.		d. STREET ADDRESS (If outside, give location) 3303 SIDNEY	

3. NAME OF DECEASED (Type or print) First Middle Last GLADYS FULLERTON			4. DATE OF DEATH Month Day Year FEB. 17 1960		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 22 1899	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OFFICE WORKER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mo	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME JOHN McENROE	13b. MOTHER'S MAIDEN NAME ROSE WATERS	14. NAME OF HUSBAND OR WIFE TAYLOR FULLERTON
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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) NO	16. SOCIAL SECURITY NO. —	17. INFORMANT Address LORETTA HINES 1600 S. 14th ST
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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) Cerebral Hemorrhage DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 331x		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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 checked="" type="checkbox"/> N <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from _____ and last saw her/him alive on _____.
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Cranner	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2. 19. 60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE FEB. 20 1960	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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24. GENERAL DIRECTOR ADDRESS Thomas Kutas 7906 Genois	25. DATE RECD. BY LOCAL REG. FEB 19 1960	26. REGISTRAR'S SIGNATURE Harold Smith M.D.
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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.

Student _____

Signature of Student Embalmer

Signed

James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 F

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.