

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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-60-028335

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>University City (30)</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7279 Maryland</b>
a. STATE <b>Mo.</b>		b. COUNTY <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>CATHERINE</b>	Middle <b>(NMN)</b>	Last <b>GEAR</b>	4. DATE OF DEATH	Month <b>JULY</b>	Day <b>10,</b>	Year <b>1960</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR	IF UNDER 24 HR
Months	Days	Hours	Min.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Dundee Scotland</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>James Simpson</b>	13b. MOTHER'S MAIDEN NAME <b>Unk. Shepard</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Gear</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>J. Scott Henderson</b>	Address <b>University City, Mo.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>UREMIA</b>		<b>2 WEEKS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>	<b>10 YEARS</b>
	DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE 420-0</b>	<b>5 YEARS</b>

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"/> No <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 _____ s.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from **May 20, 1960** to **July 10, 1960** and last saw **him** live on **July 10, 1960**  
Death occurred at **9:13** **Pam** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>H. E. Magall, M.D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>7/10/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 13, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri.</b>
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24. FUNERAL DIRECTOR <b>C.R. Lupton and Sons</b>	ADDRESS <b>7233 Delmar Bly'd.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 11 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

**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 <sup>X</sup> Arnold W. Schoene

Licensed Embalmer No. 3864  
P. O. Address A. Lewis

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