

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) St. Louis		a. STATE Mo.	b. COUNTY <del>St. Louis</del>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		c. CITY OR TOWN St. Louis	d. STREET ADDRESS 3772 Dunnica St.
Length of stay in lb 28 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JENNIE OLIVE GERIES			4. DATE OF DEATH Month Day Year March 25, 1961		
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 8-6-78	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City, town, or country) Ill. Mulberry Grove Twsp, U.S.A.	12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME James E. Plant		13b. MOTHER'S MAIDEN NAME Margaret McCullah		14. NAME OF HUSBAND OR WIFE -widow-	
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. None		17. INFORMANT Grace Gerles, St. Louis, Mo.	

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 4 yrs
IMMEDIATE CAUSE (a) <i>cardiovascular, generalized</i>			
DUE TO (b) <i>450.0 F</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture left hip subcapital</i>			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE 15 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Fell at home</i>
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20c. TIME OF INJURY Hour 7 a.m. Month, Day, Year 3-11-1961		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.) 16 Home	20f. CITY, TOWN, OR LOCATION St Louis	COUNTY	STATE Mo
21. I attended the deceased from 1959 to 1961 and last saw her/him alive on 3-25-61 Death occurred at 11:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.						

22a. SIGNATURE <i>John Orshly M.D.</i>	(Degree or title) M.D.	22b. ADDRESS 5703 Chippewa	22c. DATE SIGNED 3-27-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-28-61	23c. NAME OF CEMETERY OR CREMATORY Camp Ground	23d. LOCATION (City, town, or county) (State) Greenville, Ill.
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24. FUNERAL DIRECTOR H.D. Donnell, Greenville, Ill.	25. DATE RECD. BY LOCAL REG. MAR 27 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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RATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph J. Cassidy

Licensed Embalmer No. 754

P. O. Address E. 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.