

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-010840

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3366

STATE FILE NUMBER

FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>30 years</u>	c. CITY OR TOWN <u>St. Louis</u> 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>Homer G. Phillips Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3943 West Bell Pl.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Maxine</u> Middle <u>Gilmore</u> Last <u>Gilmore</u>			4. DATE OF DEATH Month <u>4</u> - Day <u>7</u> - Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1896</u>	9. AGE (last birthday) <u>64 years</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR 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>Maid</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>? Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Benjamin Franklin Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	14. NAME OF HUSBAND OR WIFE <u>John Gilmore-Deceased</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>-</u>	17. INFORMANT <u>Calvin Davis-3943 West Belle</u> Address <u>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>Hypertensive Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	DUE TO (c) _____
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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.) <u>443x</u>
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20c. TIME OF INJURY Hour _____ a.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"/>	20a. 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 March 1, 1961 to April 7, 1961 and last saw her alive on April 7, 1961
Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles J. Ford, M.D.</u> (Degree or title)	22b. ADDRESS <u>2801 N. Taylor</u>	22c. DATE SIGNED <u>4-8-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-11-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Berkeley City, Mo.</u>
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24. FUNERAL DIRECTOR - ADDRESS <u>Peters Undertakers - 3759 Finney Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 10 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Louise F. Woodson

Licensed Embalmer No. 4341

P. O. Address St. Louis, 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.