

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61=023331  
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5312

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Granite City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3001 Ash</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GLENNON PATRICK WHITE</u>			4. DATE OF DEATH Month Day Year <u>6 5 61</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-16</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>material receiver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McDonald Aircraft Corp.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Patrick Joseph White</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Anna Schlagel</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys Lucille White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>3001 Ash</u> <u>Gladys L. White Granite City, Ill.</u>	

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>SEMINOMA OF (L) TESTICLE E METASTASIS TO MESENTERY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>KIDNEY SHUT DOWN + PULMONARY EDEMA RESULTING IN INTRACTABLE SHOCK</u>		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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 s.m. 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
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21. I attended the deceased from JAN 1961 to 6-5-61 and last saw alive on 6-5-61  
Death occurred at 6-5-61 at 3:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William R. Green MD</u> (Degree or title)	22b. ADDRESS <u>7200 Manchester</u>	22c. DATE SIGNED <u>6-7-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) <u>St. Louis</u>	(State) <u>Missouri</u>
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24. FUNERAL DIRECTOR <u>John L. Sedlack</u>	ADDRESS <u>Granite City, Illinois</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 7 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7200 Madison

2 9 1917 1012 524

**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 John T. Sedlack

Licensed Embalmer No. 3747

P. O. Address Madison, Ill.

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.