

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007929

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1711**

STATE FILE NUMBER

AMENDED

FILED FEB 16 1962

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		c. CITY OR TOWN <b>Crystal City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 <b>304 Jefferson</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GUSTINE</b> Middle <b>E.</b> Last <b>CROSS</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>8</b> Year <b>1962</b>					
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>8-15-1900</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>hogsework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>Bismarck, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Theodore Danz</b>			13b. MOTHER'S MAIDEN NAME <b>Julia</b>			14. NAME OF HUSBAND OR WIFE <b>- - - -</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Jean Harman Festus, Missouri</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> DUE TO (b) <b>INTRACRANIAL ANEURYSM</b> DUE TO (c) <b>330x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>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		
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 a.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	
21. I attended the deceased from <b>SEPT. 27, 1959</b> to <b>FEB. 8, 1962</b> and last saw her/him alive on <b>FEB. 8, 1962</b> Death occurred at <b>10:00 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title)			22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>2/9/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Roselawn Cem.</b>		23d. LOCATION (City, town, or county) <b>Crystal City, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Gentry R. Politte</b> ADDRESS <b>Crystal City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 10 1962</b>		26. REGISTRAR'S SIGNATURE <i>Roald Smith, M.D.</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

FEB 20 1962

**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 Gentry R Politt

Licensed Embalmer No. 3481

P. O. Address Crystal City

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.