

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-024651

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

FILED JUN 318 1962

Primary Registration District

1003

Registrar's No.

6107

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
Z
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF

MEDICAL CERTIFICATION

| | | | | | | | | |
|---|--|---|--|--|---|--|----------------------------|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | St. Louis | | 2 Yrs. | c. CITY OR TOWN | | St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | BARNES HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | 936 "A" North Kingshighway | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH | | |
| CLEO | | | M. | GIBSON | | JUNE 17 1962 | | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HR Hours | Min. |
| Female | Negro | | 11/16/94 | 67 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | | |
| Maid | | Domestic | | New Orleans, Louisiana | | U. S. A. | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | |
| SIMON TAYLOR | | | ELIZABETH (UNKNOWN) | | | None | | |
| 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 | | | |
| N O | | | | | St. Louis, Missouri Natalie Taylor, 926 "A" Academy | | | |
| 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) | | | | | | | | 20 Months |
| MULTIPLE MYELOMA | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO (b) | | | | | | | | 20 3x |
| DUE TO (c) | | | | | | | | |
| 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 | 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 | | October 1960 | to | | June 17, 1962 | and last saw her | | live on |
| Death occurred at | | 12:50 PM | m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | |
| HC Bradley, M.D. | | | BARNES HOSPITAL | | | 6/17/62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | | | |
| Burial | 6/24/62 | Greenwood Cemetery | | St. Louis, Missouri | | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | | |
| Marion O. East St. Louis, Illinois | | JUN 19 1962 | | Noel Smith, M.D. | | | | |

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 Marion E. Officer

Licensed Embalmer No. 5177

P. O. Address _____

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.