

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032464

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **8421** STATE FILE NUMBER

FILED SEP 10 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

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		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
St. Louis, Missouri		St. Louis, Missouri				Missouri		St. Louis		University City		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
St. Louis Maternity				Yes <input type="checkbox"/> No <input type="checkbox"/>		1463 Coolidge				Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH		Month		Day		Year	
Gallant									Gallant			August		12		1962			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR							
female		white				8-12-1962		2		Months		Days		Hours		Min.			
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									
						St. Louis, Mo.				U. S. A.									
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
Paul Jay Gallant				Diane Terry Katz															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address							
								Diane Terry Gallant				1463 Coolidge University City, 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							
IMMEDIATE CAUSE (a)												5 minutes							
Transfusion reaction																			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																			
DUE TO (b)																			
Anemic & prematurity																			
DUE TO (c)																			
Rh incompatibility 770.5																			
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 <u>8/12/62 4:30 pm</u> to <u>6:30 p.m.</u> and last saw her/him alive on <u>8-12-1962</u> Death occurred at <u>6:30 p.m.</u> 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										
Samuel W. Jollett M.D.						8112 Delmar			Aug 22, 62										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)											
			8-31-1962		Anatomical Board			St. Louis, Mo.											
24. FUNERAL DIRECTOR ADDRESS					25. DATE REC'D. BY LOCAL REG.		REGISTRAR'S SIGNATURE												
Rowland Mortuary Svc.					4104-06 Manchester		AUG 30 1962 Rowland Smith, M.D.												

USE BLACK INK OR TYPEWRITER RIBBON

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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 _____

SSQI-SI-1

Licensed Embalmer No. _____

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.