

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013290

DO NOT WRITE  
ON THIS STUB

AMENDED **F1**

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

2925

STATE FILE NUMBER

**FED MAR 21 1963**

VS 300  
 Rev. 4/59  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>		Length of stay in 1b <b>6 days</b>	c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Little Rock Hospitals, Inc.,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3650 Shaw Ave.,</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Chester</b> Last <b>Gift</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>11,</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegrapher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (last birthday) <b>68 yrs.</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Joseph Gift</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Dickerson</b>	14. NAME OF HUSBAND OR WIFE <b>Edna Boyer Gift</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO. <b>8</b>	17. INFORMANT <b>Edna Gift,</b> Address <b>above</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes mellitus</b> DUE TO (b) DUE TO (c) <b>260x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <b>Cerebexia, Diabetic gangrene, arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
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>Mar. 5, 1963</b> to <b>Mar. 11, 1963</b> and last saw her/him alive on <b>Mar. 11, 1963</b> Death occurred at <b>8:30 P.M.,</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. Greeman M.D.</i> (Degree or title)		22b. ADDRESS <b>Mo Pac. Hospital</b> <b>1755 South Grand Blvd.,</b>	
22c. DATE SIGNED <b>3/13/63</b> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-14-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>			
24. FUNERAL DIRECTOR <b>Jay B. Smith Funeral Home-</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 13 1963</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

USE BLACK INK  
 OR  
 TYPEWRITER RIBBON

**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 W. P. Burgess

Licensed Embalmer No. 4029  
P. O. Address Maplewood

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.