

Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

42866

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2903

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFFERSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FOREKA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis Co Hosp.</u>		Length of stay in lb <u>4 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>Local</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>B.</u> Last <u>Gifford</u>			4. DATE OF DEATH <u>NOV. 19 - 1957</u>		
5. SEX <u>M</u>	6. COLOR OF RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 30 - 1883</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>19</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>OKDALE TENN</u>	
13. FATHER'S NAME <u>JOHN GIFFORD</u>			14. MOTHER'S MAIDEN NAME <u>EMILY BOURIE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-28-2281</u>		17. INFORMANT <u>John GIFFORD, Brother</u> Address <u>1184 North South St University City</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>Broncho pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</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>Post operative Cholecystectomy & Wound disruption 491X</u>					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. _____					
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>10-22-57</u> to <u>NOV. 19-1957</u> and last saw ^{her} _{him} alive on <u>NOV. 19, 1957</u> Death occurred at <u>3:05 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Richard H. King M.D.</u> (Degree or title)			22b. ADDRESS <u>601 S. Brentwood</u>		22c. DATE SIGNED <u>11-19-57</u>
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/22/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORSE MILL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>MORSE MILL - MO</u>
24. FUNERAL DIRECTOR <u>Brimmer Tom Home Home Springs Mo</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-21-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Danaher</u>

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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

Clarence M. Billo

Licensed Embalmer No. 4378

P. O. Address *St. Charles, Md.*

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.