

FILED APR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10464

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2280**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before)	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		c. CITY (If outside corporate limits, write RURAL and give OR TOWN) Maplewood	d. STREET ADDRESS (If rural, give location) 7473 Elm Ave.

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH	
a. (First) Homer	b. (Middle) Z	c. (Last) Gideon	(Month) Mar.	(Day) 7 (Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 15, 1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Amer. Car. & Fryry Co.	11. BIRTHPLACE (State or foreign country) St. Francis County, Mo.	
13a. FATHER'S NAME John Calvin Gideon			13b. MOTHER'S MAIDEN NAME Emma Layne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 489-07-4774	
17. INFORMANT'S SIGNATURE OR NAME Pearl L. Gideon			ADDRESS 7473 Elm A ve.	

18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		3 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
		DUE TO (b) Hypertension		
		DUE TO (c) Generalized Arteriosclerosis		
		II. OTHER SIGNIFICANT CONDITIONS		
		Conditions contributing to the death but not related to the disease or condition causing death. Chronic gastric ulcer		3 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
			YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
		33. IX	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3/7**, 19**50**, to **3-7**, 19**50**, that I last saw the deceased alive on **3-7**, 19**50**, and that death occurred at **8:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Albert H. Cason, M.D.	23b. ADDRESS 902-3 So. Side Natl. Bldg.	23c. DATE SIGNED 3-9-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 10, 1950	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
24d. LOCATION (City, town, or county) (State) Affton, Mo.		

DATE REC'D BY LOCAL REG. MAR 9 1950	REGISTRAR'S SIGNATURE J. B. R...	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	ADDRESS Colonial Mortuary 6464 Chipewa St.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Hutton

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 _____
Student Embalmer

Signed _____

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 this body is not embalmed, fact should be so stated above.