MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35251

File No. .....
Registered No. 9990

1. PLACE OF DEATH

County ..... Registration District No. .....
Township ..... Primary Registration District No. .....
City St Louis Mo. (No. 1921, Hebert St ..... St. ..... Ward)

2. FULL NAME Lena C. Gilmore

(a) Residence. No. ..... St., 26 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF of James Gilmore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-27-1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	6	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER Frederick Gottschall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Edward P. Gilmore
(Address) 1921 Hebert St

15. FILED OCT 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9th 1929

17. I HEREBY CERTIFY, That I attended deceased from Sep 20, 1928, to Oct 9, 1929, that I last saw her alive on Oct 9, 1929, and that death occurred, on the date stated above, at 11:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1 H R Carcinoma of
11 Stomach
139 D
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Pustulosis of Stomach
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? At Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes. DATE OF 1928
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) Dr F Hermann, M. D
, 19 (Address) 2743 N Grand

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Friedens — DATE OF BURIAL Oct 12 1929
20. UNDERTAKER Math Hermann & Son — ADDRESS 2161 E Pair Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH FOUNTAIN INK—THIS IS A PERMANENT RECORD

Harmann