

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

Do not use this space.

**31176**

File No. **8770**  
Registered No. **8770**  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City, *St. Louis* (No. *St. Johns Hospital*)

**2. FULL NAME**

*Gilbert W. Van Ormer*  
(a) Residence. No. *1712 Franklin Ave* 10 Ward.

(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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Van Ormer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 14 1871*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. of min.  
*59 4 22*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. *Storage Clerk*  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer. *Solar Ware & S. Co.*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*

10. NAME OF FATHER *John Van Ormer*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Penn*

12. MAIDEN NAME OF MOTHER *Mary Smith*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Penn*

14. INFORMANT. *Mary Van Ormer*  
(Address) *1712 Franklin Ave*

15. *Ray W. Starkey*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 5 1930*

17. *No Physician or other person*  
I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_, 19\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral apoplexy*  
*PTA (non-traumatic)*  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *7/4/21*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *J. H. P. [Signature]*, M. D.  
. 19 (Address) *Deputy, County*

\*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 *Memorial Park* DATE OF BURIAL *9 8 1930*

20. UNDERTAKER *Greg Chaves* ADDRESS *4228 [Address]*

FILED SEP - 3 1930

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR, FBI

10/1/57

RE: [Illegible]

ADVISOR: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR: [Illegible]

10/1/57

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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