

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.

AUG 7 1939

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26888

Registration District No. 784

Primary Registration District No. 260

Registrar's No. 1275

1. PLACE OF DEATH: 2  
 (a) County ST. LOUIS  
 (b) City or town W. Walnut Manor  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 7037 IDLEWILD  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME STILLBORN INFANT GNAU 501  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased JULY 14 1939  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ST. LOUIS COUNTY MO  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name GEORGE GNAU  
 13. Birthplace FORT DODGE IA  
 (City, town, or county) (State or foreign country)  
 14. Maiden name RENA OWENS  
 15. Birthplace CHARLESTON MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Gnau  
 (b) Address 7037 Idlewild

17. (a) Burial (b) Date thereof July 14 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Zion Cemetery

18. (a) Signature of funeral director Mrs. M. Schomacher  
 (b) Address 4834 Nat. Ave. St. Louis

19. (a) JUL 14 1939 (b) A. R. Meyer  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County ST. LOUIS  
 (c) City or town W. Walnut Manor  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7037 IDLEWILD  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14  
 year 1939 hour 2 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 8 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Albert Hall (M. D. number) \_\_\_\_\_  
 Address 5322 Helms Ave Date signed 7/14/39

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

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, above space should be left blank.**