

Exact statement of OCCUPATION is very important.

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1522

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Rich Hills
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 45 years (Specify whether years, months or days) 22

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shannon

(c) City or town Rich Hills
(If outside city or town limits, write "RURAL")

(d) Street No 400 Clayton
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sister Mary Gabriel

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28
year 1939 hour 12 minutes 00 P.M. M.

21. I hereby certify that I attended the deceased from 8-10, 1939, to 8-28, 1939;
that I last saw her alive on 8-28, 1939;
and that death occurred on the date and hour stated above.

4. Sex Female 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 June 24 1860
(Month) (Day) (Year)

Immediate cause of death Pulmonary Edema

Due to Chronic Myocarditis

Due to _____

Other conditions Fracture of neck of femur
(Include pregnancy within 3 months of death)

8. AGE: Years 79 Months 2 Days 4 If less than one day hr. _____ min. _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically

10. Usual occupation Religious

11. Industry or business St Marys Hospital

MOTHER FATHER { 12. Name Bernard Felchak

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name (Germany) Gering
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant's own signature Dr. M. Christ

(b) Address 6400 Clayton

17. (a) burial (b) Date thereof aug 30 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thos J. Luman

(b) Address 1519 S. ...

19. (a) AUG 28 1939 (b) J.R. Meyer
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature J. B. Caldwell M.D. (M. D. or other)

Address 6920 Clayton Date signed 8-28-39

1942

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

Do not use this space. 7

1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. 30238
 Township Rich. Heights Primary Registration District No. 111 Registered No. 1522-
 City Rich. Heights (No. St. Marys Hosp.) St. _____ Ward _____

2. FULL NAME

Sister Mary Gabriel
 (a) Residence, No. _____ St. _____ 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 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 2 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. UNDERTAKER (ADDRESS)

20. FILED 8-28 1939 MR. MARYE MASON Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pulmonary edema Date of onset _____
Chr. Myocarditis _____
Fracture neck of femur _____

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 8-4, 1939
 Where did injury occur? Richmond Heights, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Home

Manner of injury Fall to floor
 Nature of injury Fracture of neck of left femur

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. Coldwater, M. D.
 (Address) 69 20 Clayton

TEMPORARY

S-30238