DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

791 STANDARD CERTIFICATE OF DEATH

State File No. 34586

Registration District No. 1003 Primary Registration District No. _____ Registrar's No. 9124

1. PLACE OF DEATH:

(a) County _____ REC'D NOV 13 1939

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3315 Franklin
(If rural, give location)

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

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3. (a) PRINT FULL NAME Baby Gaines 5-20

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race Negro

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. (Month) 18 (Day) 1939 (Year)

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

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name Bert Gaines
13. Birthplace _____ (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Lucille King
15. Birthplace _____ (City, town, or county) Ill. (State or foreign country)

16. (a) Informant's own signature Esther Mae Sherard
(b) Address 2601 N. Whittier

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 10-26-39 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Lira Hamilton
(b) Address City Health Dept.

19. (a) OCT 26 1939 (Date received by registrar) (b) J. F. Ohedich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18 year 1939 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h_____ alive on _____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Unknown (Stillborn)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature [illegible] (M. D. or other)
Address 2601 N. Whittier Date signed 10/24/39

(Licensed Embalmer's Statement on Reverse Side)

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—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19511

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.