

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.

JAN 12 1940

791
1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **10453**

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis
(c) Name of hospital or institution: St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2629 So. Kingshighway
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Infant Gillon 450
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 6.
year 1939 hour 5 minute A. M.

4. Sex Male 5. Color or race White
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 December 6, 1939
(Month) (Day) (Year)

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

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

Immediate cause of death Still Born
Due to _____
Due to _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation None

Other conditions _____
(Include pregnancy within 3 months of death)
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name Robert Gillon
13. Birthplace Sherbrooke Canada
(City or town, or county) (State or foreign country)
14. Maiden name Helen Sawyer
15. Birthplace Matoon Illinois
(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.

16. (a) Informant's own signature Robert J. Gillon
(b) Address 2629 So. Kingshighway

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? _____

17. (a) Burial (b) Date thereof Dec. 6, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place of burial or cremation New S. S. Peter & Paul

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

18. (a) Signature of funeral director Wm. J. Robert L. & U.
(b) Address 1905 So. Grand Blvd.
19. (a) DEC 6 1938
(Date received by local registrar) (Registrar's signature)

23. Signature Eber Simpson (M.D. or other) _____
Address 3739 Gravois ave Date signed 12/6/39

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.....

Not embalmed, 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.