

Registration District No. 1003 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County Ill
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: St. Louis Children's
(d) Length of stay: In hospital or institution 4 days
In this community 4 days years, months or days

3. (a) PRINT FULL NAME Gerald Allen Foiles

3. (b) If veteran, name war Chief 3. (c) Social Security No. Chief

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Chief

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

7. Birth date of deceased 7 12 35
(Month) (Day) (Year)

8. AGE: Years 4 Months 7 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Chief

11. Industry or business _____

12. Name Cecil Foiles

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

14. Maiden name Cassie Brangenberg

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

16. (a) Informant's own signature F. Horvath

(b) Address 5005 Kingshighway

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation Kemperville, Ill.

18. (a) Signature of funeral director Albert H. Kasper

(b) Address 4700 Washington St.

19. (a) FEB 27 1940 (b) Joe Bredek
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County _____
(c) City or town Kemperville NR
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd day 26th
year 1940 hour 11th minute 35 a.m.

21. I hereby certify that I attended the deceased from 2-22, 1940 to 2-26, 1940
that I last saw him alive on 2-26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculous meningitis
Juvenile pulmonary
Due to tuberculosis Duration 3 wks
2 yrs

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

Major findings: Hyperemesis
Of operations Brain
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature Joe M. Parker (M. D. or other) yes
Address Barnes Hwy Date signed 2/26/40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MOTHER, FATHER

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

2967
2967

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 Albert G. Hopp

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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