

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3955 Washington
(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 Nellie A Gilchrist 426

3. (b) If veteran, name war _____ 8. (c) Social Security No. none

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

6. (b) Name of husband or wife John Gilchrist 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased October 10 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 8 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Reynolds

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

14. Maiden name Mary Beaver

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

16. (a) Informant John Reynolds

(b) Address 3955 Washington Ave., St. Louis

17. (a) Burial (b) Date thereof June 24th 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) JUN 24 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 3955 Washington Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 21
year 1940 hour 11 minute 00 A.M.

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.

Immediate cause of death Traumatic Subdural Hemorrhage of the brain and edema of brain.

Due to gunshot wounds to the head, chest, and

Due manner could not be ascertained

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) Open Verdict

(b) Date of occurrence unknown

(c) Where did injury occur? unknown
(City or town) (County) (State)

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

While at work? unknown (Specify type of place) (a) Means of injury unknown

23. Signature [Signature] (M. D. or other) _____
Date signed 6/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FATHER {
MOTHER {

1015-

REC'D JUL 7 1940

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 _____

H. P. Burgess

Licensed Embalmer No. _____

4029

P. O. Address _____

Maplewood

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.