

STANDARD CERTIFICATE OF DEATH

20518

State File No. \_\_\_\_\_

Registration District No. 7911

Primary Registration District No. 1603

Registrar's No. 5466

1. PLACE OF DEATH:

(a) County L  
(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 Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Hr.  
(Specify whether  
In this community 4 Mos  
years, months or days)

8. (a) PRINT FULL NAME Coleen Sandra Gant 530

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 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 6- 1- 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 1/2 hr. 10 min.

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

10. Usual occupation 5

11. Industry or business 1

MOTHER FATHER { 12. Name Coleridge Gant  
13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Leata St. James  
15. Birthplace Sparta Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant mother Mary Sheane  
(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof 6-27-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ira Hamilton

(b) Address City Health Dept.

19. (a) JUN 28/1940 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

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. 3723 Windsor  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 1  
year 1940 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from 6/1/40 1940 to 6-1 1940;  
that I last saw her alive on 6-1 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Newborn

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_ (City or town) (County) (State)

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

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

23. Signature G. E. Reese (M. D. or other) \_\_\_\_\_

Address 2601 N. Whittier Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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.**