

13-40
7-39
X23159

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **25 1940**

(a) County _____

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

(c) Name of hospital or institution: **St. Louis City Hospital, #1.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 Days**
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis** **26**
(If outside city or town limits, write "RURAL")

(d) Street No. **1419 St. Louis Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Sarah Gillian**

3. (b) If veteran, name war _____

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John Gilliam**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **January 6 1879**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **19,**
year **1940** hour **9:40** minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from **September 15,** 19**40**, to **September 19,** 19**40**;
that I last saw her alive on **September 19,** 19**40**;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	61	8	13	hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage** **5 day**

Due to **Essential Hypertension** **10 yrs.**

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

10. Usual occupation **At Home**

Due to **82a**

Other conditions **Ascending Urinary Tract Infection** **8 Day**
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name **Philip Conway**

13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Bridget Gregory**
(City, town, or county) (State or foreign country)

15. Birthplace **Louisville Kentucky**
(City, town, or county) (State or foreign country)

Major findings: **Of operations by acute cystitis, catarrhal**

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **John Gilliam**

(b) Address **1419 St. Louis**

17. (a) **Burial** (b) Date thereof **9 - 23 - 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery Cullinane Bros.**

18. (a) Signature of funeral director _____

(b) Address **1710 N. Grand Blvd.**

19. (a) **SEP 21 1940** (b) **J.F. Budick**
(Date received local registration) (Registrar's signature)

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 **[Signature]** (M. D. or other) _____

Address **1515 Lafayette Ave.** Date signed **9/20/40**

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

MOTHER FATHER

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.....

Fred Frick

Licensed Embalmer No. *3186*

P. O. Address *St. Louis, Mo.*

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, fact should be so stated above.