DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 455

Registration District No. 791 — FEB 25 1941

Primary Registration District No. 1003

Registrar's No. 455

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

1. PLACE OF DEATH:

(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 years, months or days)

In this community

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. 1054 Suburban Tracks
(If rural, give location)

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

3. (a) PRINT FULL NAME James E. Gorman

3. (b) If veteran, name war No

3. (c) Social Security No. 492-03-7456

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mable Gorman

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

7. Birth date of deceased Don't Know (Month) 1894 (Day) (Year)

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

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

10. Usual occupation Stock Clerk

11. Industry or business

FATHER
12. Name William Gorman
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Daniel Gorman
(b) Address 3021A N. Market St.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/41. (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.

19. (a) JAN 16 1941 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13, year 1941 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from January 9, 1941, to January 13, 1941, that I last saw him alive on January 13, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis — Duration 5

Due to Hypertension

Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Refused

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

23. Signature (M. D. or other)
Address 1515 Lafayette Ave., Date signed 1/13/41

(Licensed Embalmer's Statement on Reverse Side)

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. 3225

P. O. Address 1125 Hodiamont Ave.

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

If this body is not embalmed, fact should be so stated above.

. No. 2
—1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 453 X

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 453-

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

1. PLACE OF DEATH:

(a) County: St Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County:

(c) City or town: St Louis N. P. (If outside city or town limits, write "RURAL")

(d) Street No.: 1054 Suburban Track (If rural, give location)

(e) Citizen of foreign country? Welston (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: James E. Gorman

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: wd

6. (b) Name of husband or wife:

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

7. Birth date of deceased: (Month) (Day) (Year)

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

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

10. Usual occupation:

11. Industry or business:

FATHER 12. Name:

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

MOTHER 14. Maiden name:

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

16. (a) Informant:

(b) Address:

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

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

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

Immediate cause of death:

Due to: or

Due to:

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

Major findings:
Of operations:

Of autopsy:

Duration

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):

(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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Samuel Wallace (M. D. or other)

Address: 15-15 Lafayette Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.