

No. 2
-1-4-41
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32997

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7949

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
5163 CATES AVE
(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

2. USUAL RESIDENCE OF DECEASED: 066

(a) State MO (b) County _____

(c) City or town ST. LOUIS 12-17
(If outside city or town limits, write "RURAL")

(d) Street No. 5163 CATES AVE 1
(If rural, give location)

(e) Attending Physician
Physician (Yes or No)
At yes, name country _____

3. (a) PRINT FULL NAME IRENE WHITAKER

3. (b) If veteran, name war NONE

3. (c) Social Security No. UNKNOWN

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 3
year 1941 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from _____
19 _____ to _____ 19 _____

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife GILBERT 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased MAR. 28 - 1884
(Month) (Day) (Year)

that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

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

57 6 5 _____ hr. _____ min.

Immediate cause of death Chronic Myocarditis
(Infarct)

Due to _____

Due to Chronic Nephritis

9. Birthplace NEW YORK 1
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business HOME

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

Major findings: 131
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged etiologically.

MOTHER FATHER { 12. Name JAMES FOWLER

{ 13. Birthplace NEW YORK 1
(City, town, or county) (State or foreign country)

{ 14. Maiden name CATHERINE OWNEY

{ 15. Birthplace NEW YORK 1
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Joseph Fowler

(b) Address 1231 Muldrough St.

17. (a) BURIAL (b) Date thereof 10-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

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

23. Signature Ally D. Brown (M. D. or other) _____
Address Capitol Square Date signed 10/6/41

18. (a) Signature of funeral director Bullett & Kelly

(b) Address 1466 N. Taylor Ave

19. (a) OCI 6 1941 (b) Q. J. Bredeck
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

32
0
97

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 *Glenn E. Anderson*
Licensed Embalmer No. *4141*
P. O. Address *St Louis Mo.*

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.