

**FILED FEB 28 1944**

Registration District No. **518** Primary Registration District No. **1002**

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

**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:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 mos. 9 days  
(Specify whether In this community Unknown years, months or days)

**3. (a) PRINT FULL NAME** Gertrude Perkins

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race Non

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 23 1895  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>48</u>	<u>58</u>	<u>8</u>	<u>16</u> hr. — min.

9. Birthplace Ofallow MO. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

**11. Industry or business**

**MOTHER** { 12. Name Marshall Edwards

13. Birthplace Ofallow MO. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Jones

15. Birthplace Honestell MO. 0  
(City, town, or county) (State or foreign country)

**FATHER** { 16. (a) Informant Earl Mettley

(b) Address 3105 Marmon

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 15 44  
(Month) (Day) (Year)

(c) Place: burial or cremation DARK DALE

18. (a) Signature of funeral director CHAS. W. Birtz House

(b) Address 2834 W. 4th

19. (a) FEB 15 1944 (Date received by Registrar) (b) J. F. Brudick (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County St. Louis

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

(d) Street No. 3400 Franklin  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 9, year 1944 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from August 30, 1943 to February 9, 1944 that I last saw her alive on February 9, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death General Paresis

Duration Unk.

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

Due to 30

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**PHYSICIAN**

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)

(c) Means of injury \_\_\_\_\_

23. Signature H. A. Egan (M. D. or other) Address 601 N. Whittier Date signed 2/17/44

**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: Charles L. Howell  
Licensed Embalmer No. 2452  
P. O. Address 2834 Gamble

**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.**