DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19718

Registration District No. FILED JUL 15 1944 218

Primary Registration District No. 1003

Registrar's No. 5926

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: FIRMIN DESLOGE HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether

In this community years, months or days)

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. 27 N SPRING AV. (If rural, give location)

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

If yes, name country 0

000 1917 9

3. (a) PRINT FULL NAME Gates, Lottie

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife SAMUEL E. GATES

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased NOV. (Month) 26 (Day) 1864 (Year)

8. AGE: Years 79 | Months 7 | Days 4 | If less than one day hr. min.

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

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN

FATHER
12. Name EDWARD HILL
13. Birthplace (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name MARY JANE HYATT
15. Birthplace (City, town, or county) ILLINOIS (State or foreign country)

16. (a) Informant Mr. E. M. GATES

(b) Address 27 N. SPRING AV.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY (Month) 3 (Day) 44 (Year)

(c) Place: burial ~~or cremation~~ OLD SSP+P. CEMETERY

18. (a) Signature of funeral director E. J. Schnur

(b) Address 3125 Lafayette av

19. (a) JUL 3 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1944 hour 3 minute 16 P. M.

21. I hereby certify that I attended the deceased from 6-25, 1944, to 6-30, 1944 that I last saw her alive on June 30, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Semi-comatose state

Due to Heat exhaustion

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration: 3 days

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 Robert E. Fox (M. D. or other)

Address 1325 So Grand Blvd (4) Date signed 7/1/44

(Licensed Embalmer's Statement on Reverse Side) Robert E. Fox, M.D.

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

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 Jos. B. Vollmer

Licensed Embalmer No. 4014

P. O. Address St Louis M

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

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