

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6908

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:
DAKNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 69 days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County ?
(c) City or town New York City
(If outside city or town limits, write "RURAL" and location)
(d) Street No. 420 Lexington Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Homer Linwood Gafford

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mae Gafford 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 26 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 4 8 _____ hr. _____ min.

9. Birthplace Challahoochee County, Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Construction

11. Industry or business _____

12. Name James T. Gafford

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

14. Maiden name Mary Christian

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

16. (a) Informant Allie Gafford

(b) Address 1891 Peachtree, Atlanta, Ga.

17. (a) Removal (b) Date thereof 8-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus, Georgia

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) Aug 1944 (b) J. F. Brudick
(Date of local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th
year 1944 hour 2 minute 55 AM.

21. I hereby certify that I attended the deceased from May 28 1944 to August 4th 1944.
that I last saw him alive on August 4th 1944.
and that death occurred on the date and hour stated above.

Immediate cause of death Ulcerative colitis
Duration 44 mo

Due to _____

Due to 1/20

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

Major findings:
Of operations _____

Of autopsy A.S. above plus perforation of large bowel & local peritonitis

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 M. C. Abney (M. D. or other) _____

Address DARNES HOSPITAL Date signed 8/4/44

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

8069

8069

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 *Albert G. Happe*
.....
Licensed Embalmer No. *2971*
.....
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.