

FILED JAN 20 1945
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Registrar's No. 216

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location) 6 months
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Josephine B. Gore

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Joseph 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 3 1887
(Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Owings | Maryland
13. Birthplace _____ | (State or foreign country)
14. Maiden name Eleanor Grant | Kentucky
15. Birthplace _____ | (State or foreign country)

16. (a) Informant Margaret Gore
(b) Address 4109 Juniata

17. (a) Burial (b) Date thereof Jan. 10, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery
(a) Signature of funeral director Wacker Helderle
(b) Address 3634 Gravois Ave.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4109 Juniata Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6
1945 year hour 9 minute 10 P. 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 Carbureted Gas Poison
Left the window she fell to
the floor of the sanitarium
Nov. 8th 1944 at about 8:00 P.M.

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

Major findings: _____
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence Nov. 8, 1944

Where did injury occur? at home
(City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place?
City Club
(Specify type of place)

While at work? _____ (e) Means of injury fall
23. Signature J. J. Brueck (M. D. or other)
Address _____ Date signed 1/10/45

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 Frank J. England
Licensed Embalmer No. 2675
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.