

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2837  
Registrar's No. 000  
17  
63

FILED APR 6 1945  
Registration District No. 318

Primary Registration District No. 1003

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:  
Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County XX  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6737 Fyler Ave.  
(If rural, give location)  
(e) Citizen of foreign country? 0 no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Josephine M. Gilpin  
(b) If veteran, name war XX  
(c) Social Security No. XX

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 26th  
year 1945 hour 7:45 minute P. M.  
21. I hereby certify that I attended the deceased from 3-16-45  
March 26, 1945, to 45, 1945  
that I last saw her alive on 3-26, 1945  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Charles Gilpin  
6. (c) Age of husband or wife if alive 33 years  
7. Birth date of deceased January 25 1914  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Due to Apoplexy  
Due to Laryngeal apoplexy  
Other conditions Edema  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations none  
Of autopsy as above  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

8. AGE: Years 31 Months 2 Days 1  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Abram H. Black  
13. Birthplace St. Louis County Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Aima Biederer  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Gilpin  
(b) Address 6737 Fyler Ave.

17. (a) Burial (b) Date thereof 3/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Old St. Marcus Cem

18. (a) Signature of funeral director J. L. Ziegenhein & Sons  
(b) Address 7027 Gravois Ave.

19. (a) MAR 29 1945 (Date received local registrar)  
J. F. Biederer (Registrar's signature)

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 J. F. Biederer (M. D. or other) \_\_\_\_\_  
Address 3284 Prather ave Date signed 3-28-45

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..... *Sheldon Collier* .....

Licensed Embalmer No. *3382* .....

P. O. Address..... *7027 Graves* .....

**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.**