S. No. 2
M—2-43
. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25668
7836

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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

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: Mo BAPTIST Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 wk (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County ST LOUIS 96
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. 6214 BAILEY (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles T. GILLMAN
3. (b) If veteran, name war ✓
3. (c) Social Security No. 497-09-2704
4. Sex M. 0
5. Color or race Wh.
6. (a) Single, widowed, married, divorced D.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov 6 1887 (Month) (Day) (Year)
8. AGE: Years 57 Months 9 Days 28 If less than one day hr. min.
9. Birthplace do not know (City, town, or county) (State or foreign country)
10. Usual occupation Machinist
11. Industry or business Knight Machine Co
MOTHER FATHER
12. Name GILLMAN
13. Birthplace Do Not Know (City, town, or county) (State or foreign country)
14. Maiden name Do Not Know
15. Birthplace Do Not Know (City, town, or county) (State or foreign country)
16. (a) Informant N. E. O'Brien
(b) Address 1377 Hodiamont
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation ST MATHEWS Cem.
18. (a) Signature of funeral director ORTMANN F. Home
(b) Address 9222 LACKLAND OVERLAND Mo
19. (a) SEP 7 1945 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1945 hour minute 3 P. M.
21. I hereby certify that I attended the deceased from 8-30-45, 19, to 9-4-45, 19; that I last saw h alive on 9-4-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Myocardial Cl	
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)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

NOV 26 1945

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 Al C Ostmann

Licensed Embalmer No. 3478

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.