

No. 2
1-5-43
5-17-39
I X36671

FILED SEP 3 1946

Registration District No. **317** Primary Registration District No. **6076**

1. PLACE OF DEATH: *St. Louis*

(a) County *St. Louis*

(b) City or town *Bank Lawn, 20, Missouri*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *Shamrock Rest Home, 3709 Manola*
(If not in hospital or institution, write street number or location)

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

In this community _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME *Celestine Gilman*

3. (b) If veteran, name war *None*

3. (c) Social Security No. *None*

4. Sex *Female*

5. Color or race *White*

6. (a) Single, widowed, married, divorced *Widowed*

6. (b) Name of husband or wife *Chas. A. Gilman*

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

7. Birth date of deceased *April 10, 1873*
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>73</i>	<i>4</i>	<i>16</i>	hr. _____ min.

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

10. Usual occupation *None*

11. Industry or business _____

MOTHER FATHER

12. Name *Joseph Denoyer*

13. Birthplace *Unknown*

14. Maiden name *Mary Mahndee*

15. Birthplace *Unknown*

16. (a) Informant *Mr. Chas. A. Gilman*

(b) Address *7134 Pershing Ave.*

17. (a) *Burial* (b) Date thereof *8-29-46*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Parklawn Cemetery*

18. (a) Signature of funeral director *Southern Funeral Home*
6322 S. Grand Blvd.

(b) Address _____

19. (a) *8-28-46* (b) *J. M. Ganan, M.D.*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri

(a) State _____ (b) County *1. Co.*

(c) City or town *St. Louis*
(If outside city or town limits, write "RURAL")

(d) Street No. *3437a Arsenal St.*
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *August* day *26th*
year *1946* hour *2:20* P.M. minute _____ M.

21. I hereby certify that I attended the deceased from *Feb 2*
1944 to *August 26* 19 *46*
that I last saw her alive on *August 26* 19 *46*
and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic Cardio-Vascular-Renal Disease*

Duration *2 1/2 yrs.*

Due to *usual*

Due to *131A*

Other conditions *None*
(Include pregnancy within 3 months of death)

Major findings: *None*

Of operations *None*

Of autopsy *None*

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury *5*

23. Signature *Don G. Hale* (M. D. number) _____
Address *1504 So. Grand Blvd.* Date signed *8/27/46*

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

27717

DR. L. C. HAILE
1504 S. GRAND,
GR 2828.

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

J. W. Bumbley

Licensed Embalmer No. *3653*

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.