

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 20 1946
318

State File No. _____
Registrar's No. 7020

Registration District No. _____ Primary Registration District No. _____

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:
2618 Cole Street.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ 35 yrs _____ years, months or days)

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. 2618 Cole Street.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mose Gaines.

3. (b) If veteran, name war None

3. (c) Social Security No. None.

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Patsey Gaines

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased November 17, 1876
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-------|--------|------|----------------------|
| 69 | 8 | 20 | hr. _____ min. |

9. Birthplace Puducuh, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Eural Gaines

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

14. Maiden name Vinna Cartwright

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

16. (a) Informant Patsey Gaines
(b) Address 2618 Cole Street

17. (a) Burial (b) Date thereof 8/14/46.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 1416 N. Taylor Ave.

19. (a) AUG 17 1946 (Date recorded local Registrar)
J. F. Bralock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th
year 1946 hour 5:A.M. minute _____ M.

21. I hereby certify that I attended the deceased from May
1946 to July Aug. 7, 1946
that I last saw him alive on Aug. 7, 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo-Carditis

Due to cancer of the chest

Due to _____

Other conditions (Include pregnancy within 3 months of death) 55

Major findings:
Of operations _____

Of autopsy _____

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?
_____ (Specify type of place)

While at work? _____ (c) Means of injury 1

23. Signature J. F. Bralock (M. D. or other)
Address 2742A Franklin Ave. Date signed 8/8/46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Fulton G. Cullkin

Licensed Embalmer No. 4198-

P. O. Address St Louis 13. 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.