

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2515  
742  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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:  
4266 Athlone Ave. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Gas  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4266 Athlone Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY M. GATES  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex F. 5. Color or race W.  
6. (b) Name of husband or wife Charles Gates 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased Feb. 18 1864  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JAN. day 21st.  
year 1947 hour \_\_\_\_\_ minute 11 P. M.  
21. I hereby certify that I attended the deceased from  
1-1 to 1-21, 1947.  
that I last saw her alive on 1-19, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYOCARDITIS. Duration 1 yr.  
Due to \_\_\_\_\_  
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:  
(c) 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 Antonia (M. D. or other) M.D.  
Address 1194 H. O. ST. A. M. N. T. Date signed 1-22-47.

MOTHER FATHER

8. AGE: Years Months Days If less than one day  
82 11 3 hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace St. Louis Mo. U.  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home  
11. Industry or business \_\_\_\_\_  
12. Name Albert Tuckerton (1)  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)  
16. (a) Informant MR. HUBERT GATES  
(b) Address 4266 Athlone Ave.  
17. (a) BURIAL (b) Date thereof 1-24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Charles, Mo.  
18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 3840 Lindell Blvd.  
19. (a) JAN 23 1947 (Date received by registrar)  
J. F. Bredbeck (Registrar's signature)

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

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**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 W Vanmatre  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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.**