

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10843

State File No. _____

FILED APR 14 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3477**

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:
1419a Arlington Ave.
(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)

3. (a) PRINT FULL NAME JACOB GAAB

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jennie Gaab 6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased 4-10-1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 11 21 hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country) 4

10. Usual occupation Harness Maker (Retired)

11. Industry or business Herker-Meisel

12. Name Paul Gaab 4

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

14. Maiden name Louise (unknown)

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

16. (a) Informant Mrs. Victoria Curley,
(b) Address 1419a Arlington

17. (a) Burial (b) Date thereof 4-2-49
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (e) Signature of funeral director SULLIVAN BROTHERS

(b) Address 2849 North Euclid Ave

19. (a) APR 2 1947 (b) J. J. Brisch
(Date received local registrar) (Registrar's signature)

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. 1419a Arlington Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st
year 1947 hour 8:30 A. M. 11:45 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 hour.
Due to arterio-sclerotic heart several years.

Due to _____
Other conditions (include pregnancy within 3 months of death)
Major findings: arterio-sclerotic heart
Of operation 9/4/47
Of autopsy 4/19/47

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 _____

23. Signature [Signature] (M. D. or other) _____
Address 4703 North Lincoln Ave Date signed 4-1-47

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

MOTHER FATHER

Dr. Fortt,
4703 Calder Ave.

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

Robert L. Bunker

Licensed Embalmer No. 3553

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.