

FILED MAR 24 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2694**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3541a Humphrey 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 _____
years, months or days

3. (a) PRINT FULL NAME **Mary Gibson**

3. (b) If veteran, name war: **----** 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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 4th, 1857**
(Month) (Day) (Year)

8. AGE: Years **89** Months **8** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **O'Fallon- Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **home**

11. Industry or business

12. Name **John Wetzel**

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

14. Maiden name **Anna Health**

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

16. (a) Informant **Miss Ella Gibson**

(b) Address **3541a Humphrey, St. Louis, Mo**

17. (a) **burial** (b) Date thereof **Mar. 15, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **Wacker-Selders**

(b) Address **3634 Gravois, St. Louis, Mo.**

19. (a) **MAR 14 1947** (b) **J. F. Brebeck**
(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. **3541a Humphrey Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **12th**
year **1947** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **March 5 1947** to **March 12 1947**
that I last saw him **alive** on **March 12 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coracoid collapse**

Due to **Senility - ch. Hypertension**

Due to **ant. Bronchitis** **7 days**

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

Major findings: Of operations **A.S.**

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?

While at work? _____ (Specify type of place)
(e) Means of injury **0**

23. Signature **Dr. Leo P. Jony** (M. D. or other) _____
Address **2621 S. Jefferson** Date signed **3/13/47**

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

MOTHER FATHER

1600
17
9
0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Frank J. Ryland

Licensed Embalmer No.....

265

P. O. Address.....

H. Seridus

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.