

No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22247

State File No. _____

Registration District No. 214

Primary Registration District No. 103

Registrar's No. **5813**

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:
Enroute to City Hospital
(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 Missouri (b) County FOO
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1419 St. Louis Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Gillon.

3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-03-8421

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Sarah Conway Gillon
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased November 6 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>7</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation Watchman

11. Industry or business Ely-Walker Dry Goods Co.

MOTHER FATHER
 12. Name Dont Know
 13. Birthplace Dont Know
(City, town, or county) (State or foreign country)
 14. Maiden name Dont Know
 15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. William Quinn
 (b) Address 1910 North Grand Blvd

17. (a) Burial (b) Date thereof 6-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.
 (b) Address 3320 N. Kingshighway Blvd.

19. (a) JUN 13 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 11
 year 1947 hour 4 minute 0 P. M.

21. I hereby certify that I attended the deceased from 21 May 27 1947, to June 11 1947;
 that I last saw him alive on June 10, 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
 Duration 3 day

Due to Cardio-renal Disease

Due to _____

Other conditions (Include pregnancy within 3 months of death) 10/1

Major findings:
 Of operations _____
 Of autopsy _____

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 Arch. S. S. S. (M. D. or other) M. D.

Address 2202 University Date signed 6/12/47
(City, town, or county)

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.....

Fred Frick

Licensed Embalmer No..... **3186**

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 581-B-7

Registration District No. 318

Primary Registration District No. 1003

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:

(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

John Gillon

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Mr. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 67 Months 7 Days _____ (If less than one day, hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-13-47 (b) J. H. 7 Bredbeck (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

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:

(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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKING A PATTERN

S-2224¹⁷⁷