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FEDERAL SECURITY AGENCY  
National Office, 1000 ...  
**FILED JUN 15 1948**

MISSOURI DEPARTMENT OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

**A 18195**  
State File No. \_\_\_\_\_  
Registrar's No. **1336**

Registration District No. **317**

Primary Registration District No. **3063**

**1. PLACE OF DEATH:**  
(a) County **St. Louis County**  
(b) City or town **CLAYTON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 DAYS** (Specify whether  
In this community **41 YRS** years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **MO** (b) County **St. Louis Co.**  
(c) City or town **LEMA** (If outside city or town limits, write "RURAL.")  
(d) Street No. **9969 S. Broadway** (If rural, give location)  
(e) Citizen of foreign country? **NO.** (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **GEORGE GILL**

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

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **DIVORCED**  
6. (b) Name of husband or wife **MARGIE BOYD** 6. (c) Age of husband or wife if alive **?** years  
7. Birth date of deceased **DEC 3 1906**  
(Month) (Day) (Year)

**8. AGE:** Years **41** Months **5** Days **22** hr. min.

**9. Birthplace** **LEMA MO.**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Bar tender**

**11. Industry or business** \_\_\_\_\_

**12. Name** **FRED GILL**  
**13. Birthplace** **BELLEVILLE ILL.**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **EMMA METZGER**  
**15. Birthplace** **LEMA MO.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **HOSPITAL RECORD**  
(b) Address **St. Louis Co. Hospital**

**17. (a) BURIAL** (b) Date thereof **MAY 24 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **ST. TRINITY CEM.**

**18. (a) Signature of funeral director** **C. HOFFMEISTER UHL CO.**  
(b) Address **7814 S. BROADWAY**

**19. (a) 5-27-48** (b) **Carroll J. ...**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **MAY** day **25**  
year **1948** hour **6** minute **30 A.M.**  
**21. I hereby certify that I attended the deceased from** **MAY 20**, 19**48** to **MAY 25**, 19**48**;  
that I last saw him alive on **MAY 25**, 19**48**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerotic glomerulonephritis**  
**E uremici**  
Due to **diabetes mellitus**  
Due to **le.**  
Other conditions **Secondary anemia**  
(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** **H. W. Miller** (M. D. or other)  
Address **601 Broadway** Date signed **5/27/48**

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

MOTHER FATHER

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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 *James C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Bond*

**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. June 1336  
Registrar's No. 1336

Registration District No. 317

Primary Registration District No. 3163

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Clayton  
(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 George Gill

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 Married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased see 3  
(Month) (Day) (Year)

8. AGE: Years 41 Months 0 Days 0 (if less than one day) \_\_\_\_\_  
hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Mo

10. Usual occupation Student

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director [Signature]

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

181-95