

10-300
10-47
17-39
1-2506

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED SEP 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

81019
State File No. _____
Registrar's No. 8049

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Little Sisters of the Poor (No.)
(d) Length of stay: In hospital or institution 5 (Specify whether years, months or days)

3: (a) PRINT FULL NAME Catherine Gillespie
3: (b) If veteran, name war _____ 3: (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased February 29 1868 (Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Edward Gillespie
13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Mary McGrath
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James Goodwin
(b) Address 4401 Clarence Ave.

17. (a) Burial (b) Date thereof 9/15/48 (c) Place: burial or cremation Calvary (Month) (Day) (Year)

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Ave.

19. (a) SEP 14 1948 (b) J. F. Brueck (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 3225 N. Florissant Ave. 20 (If outside city or town limits, write "RURAL") (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. 12 day 12 year 1948 hour 4 minute 15 A M.

21. I hereby certify that I attended the deceased from May 12 1947 to Sept. 12 1948 that I last saw her alive on September 8 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis, Carcinoma of Sigmoid Uterus
Duration: 3 1/2 yrs

Due to _____
Due to _____
Other conditions: None (Include pregnancy within 3 months of death)

Major findings: None
Of operations: None
Of autopsy: None
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) None
(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 work) (e) Means of injury _____
23. Signature: [Signature] (M. D. or other) _____
Address: 2435 N. Grand Blvd Date signed: 9-13-48

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

MOTHER FATHER

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 *Ben Hoffman*

Licensed Embalmer No. *4366*

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.