

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

**4003**

Township.....

Primary Registration District No. ....

City *St. Louis, Mo.*

*DePaul Hospital*

File No. **29878**

Registered No. **8931**

St. .... Ward)

**2. FULL NAME**

(a) Residence: No. *5215 1/2 Palm St.* St. *6* Ward. ....

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Male*

**4. COLOR OR RACE**

*White*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*Married*

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

*Cecelia Gunn*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*Sept-27-1882*

**7. AGE**

*48*

**MONTHS**

*10*

**DAY**

*24*

If LESS than 1 day, .....hrs. or .....min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*Sergeant of Police*

(b) General nature of industry, business, or establishment in which employed (or employer)

*9th-Dist.*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Mo.*

**10. NAME OF FATHER**

*Patrick Gunn*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Ireland*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Unknown*

**14.**

INFORMANT (Address)

*Cecelia Gunn, 5215 1/2 Palm St.*

**15.**

FILED

*21 1931*

REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*Aug-18-1931*

**17.**

I HEREBY CERTIFY, That I attended deceased from

*17* Aug. 19*31*, to *Aug 18 1931* that I last saw him alive on *Aug 15 1931*, and that death occurred, on the date stated above, at *8-15-31* m.

**18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*82A*  
*97*  
*02* *Cerebral Haemorrhage*  
(duration) ..... yrs. .... mos. *1* ds.  
CONTRIBUTORY *General Arteriosclerosis*  
(SECONDARY) *(Hypertension)* (duration) *2* yrs. .... mos. .... ds.  
**18. WHERE WAS DISEASE CONTRACTED**  
IF NOT AT PLACE OF DEATH *82A*  
**DID AN OPERATION PRECEDE DEATH?** *No* DATE OF .....  
**WAS THERE AN AUTOPSY?** *No*  
**WHAT TEST CONFIRMED DIAGNOSIS?** *Clinical findings*  
(Signed) *Thomas Houston*, M. D.  
, 19 *31* (Address) *2743 N Grand*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

*Calvary Cem* *Aug 21 1931*  
**20. UNDERTAKER** *Sharkey P. S. Co. 4355 Washington*  
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

