

DEC 13 1937

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

39180

Do not use this space.

1. PLACE OF DEATH **Home G Phillips Hospital** 791
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No. **1008**
 (c) City **St. Louis** (d) Street No. **2601** N Whittier St.
 unknown (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Gertrude Harris**
 (a) Residence, No. **2024 O'Fallon** St. **27**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **unknown**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 1, 1892**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
45	9	18		

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

FATHER 13. NAME **unknown**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

MOTHER 15. MAIDEN NAME **unknown**

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

17. INFANT (ADDRESS) **Evelyn Hilliard**
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Louis** DATE **10-27-37**

19. FUNERAL DIRECTOR (ADDRESS) **W. Richter - 2500 Kutzbach**

20. **NOV 2 1937** **J. T. Predeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 19** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from **Oct. 18** 19**37** to **Oct. 19** 19**37**

I last saw h. or alive on **Oct. 19** 19**37** Death is said

to have occurred on the date stated above, at **2:20** m. **p.m.**

The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy

Date of onset **10/18/37**

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis **Clinical** Was there an autopsy? **NO**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) **L. Lewis**, M. D.

(Address) **2601 N Whittier**

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

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.)