

REC'D MAY 10 1939

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

791
1003

12890

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. **3232**
(c) City St. Louis (d) Street No. City Hospital No. 1 St.
(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

B. 66 514 Baby Gamble
(a) Residence, No. 2703 Lafayette St. 23 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 2, 1939
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 0
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. nil
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) St. Louis, Missouri
13. NAME Manard Gamble
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
15. MAIDEN NAME Edith Gage
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Hosp. Info M. Kent
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Trinity Cem DATE April 6 1939

19. FUNERAL DIRECTOR (NAME) C. Hoffmeister U. & L. Co.
(ADDRESS) 7814 S. Broadway

20. FILED APR 6 1939 J. B. Buehler
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/2/39 1939
22. I HEREBY CERTIFY, That I attended deceased from 4/2/39 1939 4/2/39 1939
I last saw h. her alive on 4/2/39 1939. Death is said to have occurred on the date stated above, at 8.30 p
The principal cause of death and related causes of importance were as follows:

Prematurity

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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 John T. Wilson, M. D.
(Signed)..... (Address) City Hospital No. 1

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3471*

P. O. Address _____

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, above space should be left blank.