

DEC 17 1939
Registration District No. 1000

Primary Registration District No. _____

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

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.

1. PLACE OF DEATH:

(a) County 3

(b) City or town St. Louis

(c) Name of hospital or institution:
Lenox Hotel Found Dead

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME John F. Gilmore U.S.

8. (b) If veteran, name war *****

3. (c) Social Security No. unk.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Grace Halpin Gilmore

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 16 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

59	1	14	hr. min.
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9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Calculator

11. Industry or business Fairmont Race Track

MOTHER FATHER { 12. Name Michael Gilmore

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Nolan
(City, town, or county) (State or foreign country)

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary W. ...

(b) Address New York City

17. (a) Burial (b) Date thereof Nov 6 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New York N.Y.

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) NOV 2 1939 (b) J. F. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 2

(a) State New York (b) County _____

(c) City or town New York N.Y.
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
No attending physician

20. DATE OF DEATH: Month Oct. day 30th
year 1939 hour 9 minute 0 P. A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis, Coronary Sclerosis
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 8 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 Joseph M. ... (M. D. or other) _____

Address Deputy ... Date signed _____

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.....

Francis J. Quinn

Licensed Embalmer No. *2245*

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, above space should be left blank.