

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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

38323  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No..... Registered No. 10162  
(c) City St. Louis (d) Street No. 38 Mary's Ave. S. East 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

(a) Residence, No. 416 Baby Gilbert - Skillborn St. 12  
616 No Union Ave (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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 17, 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
3 11 11 11 11  
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.  
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 Mo.

FATHER 13. NAME Adolph Gilbert  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

MOTHER 15. MAIDEN NAME Jarothy Rice  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

17. INFORMANT Adolph Gilbert  
(ADDRESS) 616 No Union

18. BURIAL, CREMATION, OR REMOVAL  
PLACE City Cem DATE 11-30-39

19. FUNERAL DIRECTOR (NAME) Mrs Hamilton  
(ADDRESS) City Health Dept.

20. NOV 29 1939 19.....  
J. F. Brubaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-17-39 1939  
22. I HEREBY CERTIFY, That I attended deceased from 11/17/39 to 11/17/39  
I last saw him alive on 11/17/39 still born 1939 Death is said to have occurred on the date stated above, at 11:15 A.M.  
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? No  
If so, specify Ralston's Mill  
(Signed) Ralston S. Milled, M. D.  
(Address) 1536 Papin St.

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**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.....

Licensed Embalmer No.....

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.**