

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.

JAN 12 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: -

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital, #1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 26 Days  
 (Specify whether  
19 yrs  
 In this community  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 23  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2347 Albion Place  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 19 yrs years.

3. (a) PRINT FULL NAME Elizabeth Gurley 640

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F. 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 15, 1871  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 5 15 hr. \_\_\_\_\_ min.

9. Birthplace Tennessee  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business John Robbins

12. Name \_\_\_\_\_ 18. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name Louise Morgan  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Elizabeth Gurley  
 (b) Address 1413 Missouri Ave

17. (a) Removal (b) Date thereof 12/2/39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
Matthews, Missouri

18. (a) Signature of funeral director W. M. McFarland  
 (b) Address 2301 Lafayette Ave

19. (a) 12-1-1939 (b) J. B. Smith  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30,  
 year 1939 hour 10:05 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from November  
5, 1939 to November 30, 1939.  
 that I last saw h. er alive on November 30, 1939,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None  
 Of autopsy None  
 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)  
 (a) Means of injury \_\_\_\_\_  
 23. Signature W. M. McFarland (M. D. or other) \_\_\_\_\_  
 Address 1515 Lafayette, 11/30/39 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

*H. R. Cooper*

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

**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.**