

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26659

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6555

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(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) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3953 St. Ferdinand Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1940 hour I minute 0 P.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 Chronic Glomerular Nephritis  
Chronic Pulmonary Tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operation \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external cause, 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? 844

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury 5

28. Signature J. F. Brodeur (M. D. or other) 5

Address Superior Date signed 8/2/40

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Rose Gavin 150

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, divorced, Single

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

7. Birth date of deceased. July 25 1895  
(Month) (Day) (Year)

8. AGE: Years 45 Months 0 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Patrick Gavin

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

14. Maiden name Eileen Welsh

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

16. (a) Informant Michael Gavin

(b) Address 3953 St. Ferdinand

17. (a) Burial (b) Date thereof Aug. 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros

(b) Address 1710 N. Grand Blvd.

19. (a) AUG 2 1940 (b) J. F. Brodeur  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**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.....

*Fred Frick*

Licensed Embalmer No. *3186*

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.**