

SEP 25 1940

Registration District No. 7911

Primary Registration District No. _____

Registrar's No. 6585

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST. LOUIS
 (If outside city of town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2500 S. 18th ST. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 (years, months or days)

8. (a) PRINT FULL NAME AGNES GILL 4003. (b) If veteran, name war NO 3. (c) Social Security No. NO4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Widow6. (b), Name of husband or wife, MICHAEL J. GILL 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased FEBRUARY 27-1868
(Month) (Day) (Year)8. AGE: Years 72 Months 5 Days 5 If less than one day hr. _____ min. _____9. Birthplace ALTON ILLINOIS
(City, town, or county) (State or foreign country)10. Usual occupation NIL

11. Industry or business

12. Name JACOB STRUBEL
 18. Birthplace GERMANY 6
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace GERMANY 6
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kathryn Boughton(b) Address Chicago Illinois17. (a) BURIAL (b) Date thereof AUG. 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CALVARY CEMETERY18. (a) Signature of funeral director E. J. Schmur(b) Address 3125 Lafayette St. Ave19. (a) AUG 2 1940 (b) J. G. Biedack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST. LOUIS, 23
 (If outside city of town limits, write "RURAL")
 (d) Street No. 2500 S. 18th ST.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1
year 1940 hour 9 minute 30 p.m.21. I hereby certify that I attended the deceased from 7/27/40
19____ to 8/1/40 19____;that I last saw her alive on 8/1/40 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Haemorrhage 3 weeksDue to Arterio-Sclerosis
Hypertension

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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 Paul B. Webb (M. D. or other) MDAddress 1920 Sidney Date signed 8/1/40

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

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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.....

Jose B. Rollme

Licensed Embalmer No. *4014*

P. O. Address

3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.