

No. 2
1-13-40
17-30

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

331570

State File No. _____

OCT 10 1940

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 1710

1. PLACE OF DEATH: St. Louis County
 (a) County St. Louis
 (b) City or town Riverview Heights Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Mary's Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3615 Hereford St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME WALTER DAVID GAUNT

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased April 28 1940
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>4</u>	<u>11</u>	<u>5</u>	<u>5</u> hr. <u>0</u> min.

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

10. Usual occupation Baby

11. Industry or business None

12. Name Walter Ford Gaunt

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

14. Maiden name Leathery Farnsworth

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

16. (a) Informant W. F. Gaunt

(b) Address 3615 Hereford St

17. (a) Burial (b) Date thereof 9 10 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Walter Ford Gaunt

(b) Address 6536 Clayton Rd

19. (a) SEP 9 1940 (b) W. R. Meyer
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8th
year 1940 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from 9/7/40
1940 to 9/8 1940
that I last saw him alive on 9/8 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 4 hrs

Due to Congenital heart disease

Due to 157c

Other conditions Bronchopneumonia 3 days
(Include pregnancy within 3 months of death) (X-ray)

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) (c) Means of injury _____

23. Signature Mark H. Donoran M.P. (M. D. or other) _____

Address St. Mary's Hosp Date signed 9/8/40

St. Louis

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.....

Wm F Rogers

Licensed Embalmer No.

3960

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, fact should be so stated above.