

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

34058

Registrar's No.

8755

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County St. Louis. Mo.
(b) City or town St. Louis. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days.
In this community 50 years. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Katie Gus.

3. (b) If veteran, name war _____ 8. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 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 November. 17. 1889.
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 5 If less than one day hr. _____ min.

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

10. Usual occupation None.

11. Industry or business _____

12. Name Unknown.

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

14. Maiden name Unknown.

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

16. (a) Informant's own signature E. Sanders.

(b) Address 5800 Arsenal. St.

17. (a) Burial (b) Date thereof 10-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director John A. Genteman

(b) Address 5077 Durant Ave.

19. (a) OCT 24 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST. LOUIS
(c) City or town Missouri State School
(If outside city or town limits, write "RURAL")
(d) Street No. UNKNOWN 5806 Arsenal
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22.
year 1940 hour 1:45 pm minute _____ P. M.

21. I hereby certify that I attended the deceased from Oct 17. 1940 to Oct 22. 1940
that I last saw her alive on October 22. 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis
tuberculosis

Due to _____

Due to _____

Other conditions Tuberculosis of
(Include pregnancy within 3 months of death)
intestines

Major findings: _____
Of operations _____

Of autopsy as above

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 Dr. Maxwell (M. D. or other)
Address Isolation Hospital Date signed 10/24/40

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.....

Albert J. Hopper

Licensed Embalmer No. 2971

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.