

Registration District No. 16 1940
791 Primary Registration District No.

1. PLACE OF BIRTH:

(a) Country St. Louis Mo
(b) City or town St. Louis Mo
(c) Name of hospital or institution 4219 Westmenester Pl
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 (Specify whether years, months or days)
In this community 20 years, months or days

3. (a) PRINT FULL NAME MARY GAMBON

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

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 Mar 1, 1873 (Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 27 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Margaret Gambon

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

14. Maiden name Bridge Welch

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

16. (a) Informant Margaret Welch

(b) Address 4219 Westmenester Pl

17. (a) Buried (b) Date thereof Oct 30, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director J. J. O'Brien

(b) Address 1319 Union St

19. (a) OCT 29 1940 (Date received local registrar) (b) J. J. O'Brien (Registrar's signature)

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. 4219 Westmenester Pl (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30 year 1940 hour 2 am minute _____ M.

21. I hereby certify that I attended the deceased from Sept 30 1940 to Death, 19____; that I last saw him alive on Oct 28 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis (From history) 10 yrs.
Due to Chronic Interstitial Nephritis 10 yrs.

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
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) no
(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 fall
23. Signature J. J. O'Brien (M. D. or other) M.D.
Address 4448 SHAW BL Date signed 10-30-40

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.....

Licensed Embalmer No.

P. O. Address.....

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, fact should be so stated above.