

JAN FEB 25 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

557
Do not use this space.

1. PLACE OF DEATH

(a) County..... 3 Registration District No..... 791
(b) Township..... Primary Registration District No..... 0003 Registered No..... 55796
(c) City..... St. Louis (d) Street No..... 5246 Maple St. (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

amelia GILBERT
(a) Residence, No. 3227 WOODSON Rd. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF OR WIFE OF unmarriage
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 13, 1875
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 8 4
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. own home
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Pearl, Ill. / (STATE OR COUNTRY)

13. NAME Mr. John Drake

14. BIRTHPLACE (CITY OR TOWN) Clarksville, Mo. / (STATE OR COUNTRY)

15. MAIDEN NAME Amelia Kessinger

16. BIRTHPLACE (CITY OR TOWN) Kessinger, Mo. / (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Alberta Kuna 5246 Maple

18. BURIAL, CREMATION, OR REMOVAL PLACE Sunnyside, Mo. DATE 1/19/41

19. FUNERAL DIRECTOR (NAME) Robert N. Flapper (ADDRESS) 4700 Washington Av.

20. FILED JAN 18 1941 J. F. Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 17 - 1941
22. I HEREBY CERTIFY That I attended deceased from Jan. 1938, to Jan. 17, 1941. Last saw her alive on Jan 16, 1941. Death is said to have occurred on the date stated above, at 8:00 P.M.
The principal cause of death and related causes of importance were as follows:

Pulmonary infarct
Other contributory causes of importance: Influenza, Semilitary, Chronic Bronchitis
Name of operation none Date of
What test confirmed diagnosis? Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19... Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Nature of injury
24. Was disease or injury in any way related to occupation of deceased? No If so, specify (Signed) Henry Rosenberg, M. D. (Address) 4503 Page St.

WHILE FEMINIST, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

I X14028

NOTE.
A. H. Jones
4500
Phone Recorder 0500

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 *Robert J. Hays*

Licensed Embalmer No. *1861*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5377

Registrar's No. 567

Registration District No. 791

Primary Registration District No. 1003

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

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:

(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)

3. (a) PRINT FULL NAME Amelia Gilbert

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 | 8 | 4 | _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1/18/44 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. 3327 Woodson Rd W.P.
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country Overland

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan day 17
year 1944 hour _____ minute _____ 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 _____

Duration

Due to _____

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) _____

(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 Henry E. Rosenberry (Physician or other)

Address _____ Date signed _____

SUPPLEMENTARY

