

No. 2  
-1-4-41  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26953

State File No. \_\_\_\_\_

6745

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

FILED SEP 17 1941 791  
Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(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: BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days.  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3527 Pestalozzi St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mr. John Bruce Gilbert  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 488-09-8932

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mamie Gilbert  
6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased April 6, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 4 11 hr. \_\_\_\_\_ min.

9. Birthplace West Chester Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business United Drug

12. Name John W. Gilbert

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

14. Maiden name Carrie Lundy

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

16. (a) Informant Mrs. Mamie Gilbert

(b) Address 3527 Pestalozzi St.

17. (a) Removal Motor (b) Date thereof Aug. 20, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alton Illinois

18. (a) Signature of funeral director Weick Bros. Und. Co.

(b) Address 2201 S. Grand Bl.

19. AUG 19 1941 (Date received local registrar)  
J. T. Bredsh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18  
year 1941 hour 9 minute 15 P.M.  
21. I hereby certify that I attended the deceased from Aug 16  
19 41 to Aug 18 19 41  
that I last saw him alive on Aug 18 19 41  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Bronchopneumonia  
Due to Anemia  
Due to Carcinoma prostate  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations Carcinoma prostate  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature John J. Madala (M. D. or other) \_\_\_\_\_  
Address BARNES HOSPITAL Date signed \_\_\_\_\_

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

MOTHER FATHER

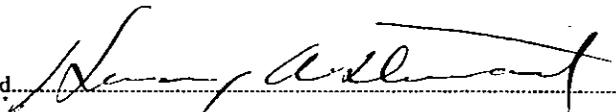
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**STATEMENT BY LICENSED EMBALMER**

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. 3722

P. O. Address 412 Duchouquette St.

**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.**