

No. 2.
-1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32689

FILLED OCT 7 1941

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2001

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo
(Specify whether years, months or days)

In this community 5 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2630 Spruce
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME JAMES GILBERT

3. (b) If veteran, name war _____

3. (c) Social Security No. 495-14-950

4. Sex M

5. Color or race N

6. (a) Single, widowed, married, divorced SA

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased 4 19 1918
(Month) (Day) (Year)

8. AGE: Years 23 Months 5 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Bellevue 1 Ark
(City, town, or county) (State or foreign country)

10. Usual occupation Tobacco worker

11. Industry or business Tobacco manufacture

12. Name Tom Gilbert

13. Birthplace Bellevue 1 Ark
(City, town, or county) (State or foreign country)

14. Maiden name Maella Eyer

15. Birthplace Bellevue 1 Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hosp.

17. (a) Removal (b) Date thereof 10-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marianna Ark.

18. (a) Signature of funeral director F. A. Green

(b) Address 2915 Franklin Ave.

19. (a) OCT 1 - 1941 (b) J. M. Barron md
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29 year 1941 hour 10 minute 47 A.M.

21. I hereby certify that I attended the deceased from July 1, 1941 to Sept 29, 1941

that I last saw him alive on Sept 29, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis lungs Duration 6 mos

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 13 1/2

Major findings: Of operations _____

Of autopsy Tuberculosis and intercostals

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 Robert C. Sweet (M. D. or other) _____

Address Robert Koch Hosp Date signed 9/29/41

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

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15-64

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

J. A. Green

Licensed Embalmer No. *2963*

P. O. Address. *2915 Franklin*

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.