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S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5242
Registrar's No. _____

FILED JUN 14 1943 18

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County Saint Louis, Missouri

(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Abt. 30 years years, months or days)

3. (a) PRINT FULL NAME GEORGE S. GABLES

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male 5. Color or Race Negro 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 About 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Abt. 72 hr. _____ min.

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

10. Usual occupation Butler

11. Industry or business Private family

12. Name Unavailable

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

14. Maiden name Unavailable

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

16. (a) Informant Clara Maude Lewis

(b) Address 3808 Cook Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/43 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) JUN 7 1943 (Date received local registrar) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4411 a West Belle Place (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5th year 1943 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3/13/43 19____, to 6/5/43 19____; that I last saw h. im alive on 6/4/43 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 2 Wks.

Due to Chronic interstitial Nephritis Unk.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 131

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 [Signature] (M. D. or other) _____ Address 828a N. Jefferson avenue Date signed _____

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.....

William C. McDowell

....., Registered Apprentice No.....

working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. 2114

P. O. Address 1711 North Taylor Avenue

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.