

S. No. 2
DM-2-43
V. 5-17-39
-1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28001

State File No. _____
Registrar's No. **6295**

FILED JUL 17 1943 **318**

Registration District No. _____ Primary Registration District No. **1000**

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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days**
In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Leroy Gandy**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **MALE** 5. Color of race **C** 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 **3 27 1925**
(Month) (Day) (Year)
8. AGE: Years **18** Months **3** Days **11** If less than one day hr. _____ min.

9. Birthplace **ST LOUIS MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **STUDENT**

MOTHER FATHER

11. Industry or business _____
12. Name **WILLIAM E. GANDY**
13. Birthplace **STARKSVILLE MISS**
(City, town, or county) (State or foreign country)
14. Maiden name **MARION MERRINAN**
15. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **William C. Gandy**
(b) Address **1300 S. 3rd St**
17. (a) **BURIAL** (b) Date thereof **7-12-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or removal **Washington Park Blue Lane**
18. (a) Signature of funeral director **J. T. Brebeck**
(b) Address **3103 Washington**
19. (c) **JUL 17 1943** (Date received local Registrar) (Registrar's signature)

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. **1500 S. 3rd St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8,**
year **1943** hour **12** minute **40 A.** M.
21. I hereby certify that I attended the deceased from **June 26,** 19**43** to **July 8,** 19**43**; that I last saw him alive on **July 8,** 19**43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Duration **Unk.**

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 **Alus Moore** (M. D. or other) Address **2601 Whittier** Date signed **7/10/43**

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

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4219 E Hazel

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.