

32531

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 22 1943

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2119

1. PLACE OF DEATH:

(c) County St. Louis
 (b) City or town Olivette
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
9614 Olive St. Rd.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town Olivette
 (If outside city or town limits, write "RURAL")
 (d) Street No. 9614 Olive St. Rd.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Asa Seward Gullick
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced Div. 3
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 3, 1386.
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 2 15 _____ hr. _____ min.

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

10. Usual occupation retired waiter

11. Industry or business _____

12. Name Seward Gullick,

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

14. Maiden name Katherine Penn.

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

16. (a) Informant Walter Todd

(b) Address 9614 Olive St. Rd.

17. (a) burial (b) Date thereof 9/21/43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery.

18. (a) Signature of funeral director Louis H. Bopp, Inc.
 (b) Address Kirkwood, Mo.

19. (a) SEP 21 1943 (b) C. J. McJannet
 (Date of medical registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
 year 1943 hour 3 minute 20 p. M.
 21. I hereby certify that I attended the deceased from Aug 9 1943 to Sept 15 1943
 that I last saw him alive on Sept 18
 and that death occurred on the date and hour stated above.

Immediate cause of death
chronic myocarditis
and hypertension
 Due to _____
 Due to _____

Other conditions 93d
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 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 A. B. J. Jernig (M. D. or other) _____
 Address 6 N. W. 6 Ave / mo Date signed 9/22/43

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

600

386
2/43

SEP 22 1948

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.....

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, fact should be so stated above.