

FILED JAN 4 1944 18  
Registration District No. **1944 18**

Primary Registration District No. **1003**

Registrar's No. **11666**

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

**1. PLACE OF DEATH:**

(a) County St. Louis

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

(c) Name of hospital or institution 3915 Finney ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay in hospital or institution abt. 37 years  
(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 St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3915 Finney ave.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

**3. (a) PRINT FULL NAME** SARAH GIBSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 20  
year 1943 hour 10 minute 40 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 9 1880  
(Month) (Day) (Year)

Immediate cause of death Cerebral apoplexy

Due to J.S.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>63</u>	<u>0</u>	<u>10</u>	hr. _____ min.

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

Duration \_\_\_\_\_

Physician \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Lysonnia Ganaway  
(b) Address 3915 Finney ave

17. (a) Burial (b) Date thereof Dec 27/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Jackson 12/27/43

18. (a) Signature of funeral director F. A. Sheen  
(b) Address 2915 Franklin ave

19. (a) DEC 26 1943 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Alfred W. Perry (M. D. or other) \_\_\_\_\_  
Address Slippery, Missouri Date signed 12/21/43

**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. Hean*

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.**