

FILED FEB 1 1944
318

Register District No. 1002

Registrar's No. 738

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis
(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 11 days
In this community 22 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis 12
(If outside city or town limits, write "RURAL") 991
(d) Street No. 1927 Linden
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Rachel Gaines

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

4. Sex F 5. Color 3 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 July 22 1890
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 30 If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business.....

12. Name Henry Kelly

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

14. Maiden name Mary Smith

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

16. (a) Informant Mac Jessie Jordan

(b) Address 702nd N. Jefferson

17. (a) Burial (b) Date thereof 1/27/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

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

(b) Address 2915 Fishburne ave

19. (a) JAN 25 1944 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21
year 1944 hour 12 minute 05 A. M.

21. I hereby certify that I attended the deceased from January 20 1944 to January 21 1944;
that I last saw him alive on January 21 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Lobar Pneumonia</u>	<u>6 days</u>
<u>Diabetic Coma</u>	<u>3 days</u>

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death).....

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) (c) Means of injury.....

23. Signature S. E. Smith (M. D. ~~certified~~)
Address 2601 N Whittier St Date signed 1-24-44

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.....

.....
working under my personal supervision.

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

Signed *J. A. Allen*.....

..... 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.