

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8946**

Registration District No. **6 1944**

Primary Registration District No. **1003**

Registrar's No. **2970**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9

(d) Street No. 414 Market St.
(If rural, give location) 23

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

3. (a) PRINT FULL NAME NEAL ALEX GABA

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

4. Sex Male 5. Color or race White

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 September 17th ?
(Month) (Day) (Year)

8. AGE: abt Years Months Days If less than one day
58 hr. min.

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

10. Usual occupation Laborer

11. Industry or business unk

12. Name Dave

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

14. Maiden name Mary

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Autopsy Report (b) Date thereof 3-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation St. Louis

18. (a) Signature of funeral director D. Ruckler

(b) Address 3500 Rector St

(c) MAR 20 1944 (Date received) (Registrar's signature) J. J. Branch

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22nd
year 1944 hour 6:35 minute P. M.

21. I hereby certify that I attended the deceased from March 14th
1944 to March 22nd, 19 44
that I last saw him im alive on March 22nd, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary thrombosis

Due to h

Due to h

Other conditions (include pregnancy within 3 months of death) 1/2

Major findings:
Of operations h

Of autopsy h

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? _____

(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature Fran J. Laryette (M.D. or other) h
Address 1515 Lafayette Date signed 3/23/44

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.....

....., 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.