

FILED JUN 30 1944 18

Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(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 16 days  
In this community 30 years (Specify whether years, months or days) 0

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. 4 No. Compton  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... 0

000  
217  
9

3. (a) PRINT FULL NAME Della Gaines

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Elwood Gaines 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased January 10, 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 5 7 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Tom Churchill  
13. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Pearl Reynolds  
15. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Elwood Gaines  
(b) Address 4a N. Compton Avenue

17. (a) Burial (b) Date thereof 6/21/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclade Avenue (3)

19. (a) JUN 21 1944 J. F. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17,  
year 1944 hour 3 minute 05 P. M.

21. I hereby certify that I attended the deceased from June  
1, 19 44 to June 17, 1944;  
that I last saw her alive on June 17, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease U  
Duration Unk.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 0

23. Signature [Signature] (M. D. or other) 0  
Address [Signature] Date signed 6/20/44

PHYSICIAN

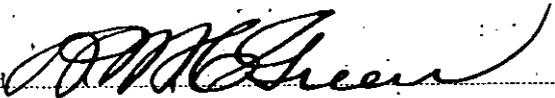
Underline the cause to which death should be charged statistically.

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. 1173

P. O. Address 3517 S. 4th St. S. C.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**