

No. 2
OM-5-43
v. 5-17-39
I X36671

FILED NOV 30 1944
318

State File No. _____
Registrar's No. 9897

Registration District No. _____ Primary Registration District No. 1003

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:
St. John's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ethel Gaines

3. (b) If veteran, name war _____
 Nil

3. (c) Social Security No. Nil

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

6. (b) Name of husband or wife Odis Gaines
 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased May 28 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49	5	22	hr. _____ min.
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9. Birthplace Zalma Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel G. Virgin

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

14. Maiden name Emma Jane Robbins

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

16. (a) Informant Odis Gaines
 (b) Address 1287 Hodiamont Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-44
(Month) (Day) (Year)
 (c) Place: burial or cremation Lutesville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) NOV 21 1944 (Date received local registrar) J. F. Bredek (Registrar's signature)

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. 1287 Hodiamont
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
 year 1944 hour 11:30 minute A. M.

21. I hereby certify that I attended the deceased from 3-31-44 1944 to Nov 20 1944
 that I last saw her alive on Nov 19 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Pancreatitis Acute

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?

(Specify type of place)
 While at work? _____ (e) Means of injury 0

23. Signature R. N. [unclear] (M. D. or other)
 Address 3903 Park Dr Date signed 11/21-44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

DEC 8 1944

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..... *E. W. Wilkins*
..... Licensed Embalmer No..... *3575*
..... 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.