

FILED JAN 20 1945

Registration District No. **318**

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: **City Sanitarium**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 mos. 12 ds.** **0**
(Specify whether years, months or days)

In this community **10 yrs.**
(years, months or days)

3. (a) PRINT FULL NAME **GEORGE GASKILL**

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

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Mar**

6. (b) Name of husband or wife **Myra Gaskill** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 10, 1903**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
41	7	26	_____ hr. _____ min.

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

10. Usual occupation **Chef/Baric**

11. Industry or business _____

MOTHER FATHER

12. Name **William F. Gaskill**

13. Birthplace **White Haven Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizag Henning**

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

16. (a) Informant **Mrs. John Gaskill**

(b) Address **3646 Arsenal St. St.**

17. (a) **Burial** (b) Date thereof **1-8-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hannibal, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JAN 9 1945** (b) **J. F. Bredet**
(Date received local registrar) (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. **5300** **3646 Arsenal**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **Jan** day **6th**, year **1945** hour **3.30** minute **A.** M.

21. I hereby certify that I attended the deceased from **Sept. 24th**, 19 **44** to **Jan. 6**, 19 **45**
that I last saw him alive on **Jan 6**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pulmonary Tuberculosis

Due to **Paranoid State** **9/24/44x**

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 **Robert P. ...** (M. D. or other) **1/6/45**
Date signed _____

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

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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 *Albert W. Halpe*

Licensed Embalmer No. *1869*

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.