

5-43  
5-17-39  
X36671

FILED MAR 28 1945 318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Enroute City Hospital  
(If not in hospital or institution, write street number or location) 3  
(d) Length of stay: In hospital or institution. None (Specify whether  
In this community 25 Years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Sarah A Gann

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Jan 1 1849  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
96 2 14 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Cottner

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

14. Maiden name Unknown

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

16. (a) Informant Monroe Gann

(b) Address 3032 Caroline

17. (a) Burial (b) Date thereof 3/17/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) MAR 16 1945 J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1414 California  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 45 hour \_\_\_\_\_ minute 9 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Coronary Sclerosis  
Atherosclerosis  
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 3  
23. Signature Patricia E. Taylor Dep. Coroner  
(If D. or other)  
Address 1300 Clark Date signed 3/16/45

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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.....

L. R. Cooper  
Licensed Embalmer No. 3633

P. O. Address. 2317 Lafayette

**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.**

Registration District No. 318

Primary Registration District No. 1003

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(c) Name of hospital or institution:  
(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 Sarah A. Gunn  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years 96 Months 2 Days 2 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace.....  
(City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....

17. (a)..... (b) Date thereof.....  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) APR 10 1945 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

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(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

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that I last saw him/her alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:  
Of operations.....  
Of autopsy.....

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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(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.....

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

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