

FILED APR 13 1945

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

318

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

1003

Registrar's No. \_\_\_\_\_

2220

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Christian 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 JOHN P GILLICK

3. (b) If veteran, name war No 3. (c) Social Security No. 490-18-9682

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

6. (b) Name of husband or wife Mary A. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased 4-6-1875  
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 23 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

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

12. Name John P Gillick  
New York

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

14. Maiden name Jennie Vevvian

15. Birthplace New York  
Mary A Gillick (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address 4115 Maffitt ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan Bro's

(b) Address 2849 N. Euclid ave

19. (a) MAR 30 1945 (b) J. J. Bredich (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. 4115 Maffitt ave.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th  
year 1945 hour 2 minute 38 P. M.

21. I hereby certify that I attended the deceased from 10-20-44  
to 3-29 1945  
that I last saw him alive on 3-29-45 and that death occurred on the date and hour stated above.

Immediate cause of death Carbami of liver

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) 1/24

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 \_\_\_\_\_

23. Signature Sullivan (M. D. or other) m.d.  
Address 5074 N. Union Date signed 3-30-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

60  
17  
9

DR HARRY A KLEIN  
5074 N Union MU1030 ✓

Res 1256 S. ROLAND MUISIS

Friday 10<sup>am</sup>

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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 *Robert D. Dinkman*

Licensed Embalmer No. *3503*

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.