V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14544

FILED APR 23 1945

Registration District No. 577

Primary Registration District No. 6076

Registrar's No. 795

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mount St. Rose Sanitorium, S. Bdway 9101
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Not stated (Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3825 Potomac St.
(If rural, give location)
(e) Citizen of foreign country? No. 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME PAGE GILLASPIE

3. (b) If veteran, name war No.

3. (c) Social Security No. 489-10-0739

4. Sex Male 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Clara

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Aug. (Month) 21 (Day) 1904 (Year)

8. AGE: Years 40 | Months 7 | Days 8 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Mechanic

11. Industry or business Atlas Towel Co.

FATHER
12. Name Page Gillaspie, Sr.
13. Birthplace Cincinnati (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name Anna Landauer
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Clara Gillaspie
(b) Address 3825 Potomac St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave.

19. (a) APR 2 1945 (Date received local registrar) (b) Dr. E. G. McGovran Dy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1945 hour 2 minute 35 AM.

21. I hereby certify that I attended the deceased from July 8, 1944, to March 29, 1945; that I last saw him alive on March 28, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fan Adv. Pell. Tbc.	2 yrs
Due to	
Due to	
Other conditions Tbc. Enteritis + peritonitis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Same 134

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

23. Signature John C. Murphy (M. D. or other) M. D.
Address 9101 So. Broadway Date signed 3-29-45

(Licensed Embalmer's Statement on Reverse Side)

MAR 19 1947

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.....

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.