

S. No. 2
DM-8-43
V. 5-17-39
I X37823

15138

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4131**

FILED MAY 21 1945
878

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution:
5442a Morganford
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **5442a Morganford**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Catherine Gintel**
(b) If veteran, name war _____ (c) Social Security No. **489-12-1157**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Charles Gintel** 6. (c) Age of husband or wife if alive **48** years
7. Birth date of deceased **September 2, 1898**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **6**
year **1945** hour **5** minute **17** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years Months Days If less than one day
46 **8** **4** hr. min.

Due to **Coronary Occlusion**
Due to **Chronic Corbetis non-specific**
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **Louisiana**
(City, town, or county) (State or foreign country)
10. Usual occupation **Waitress**
11. Industry or business _____
12. Name **John Johnston**
13. Birthplace **Rhode Island**
(City, town, or county) (State or foreign country)
14. Maiden name **Ellen Phillip**
15. Birthplace **Ok.**
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **John Johnston**
(b) Address **3819 Manola**
17. (a) **Burial** (b) Date thereof **5/10/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bellefontaine**
18. (a) Signature of funeral director **Edith E. Ambruster**
(b) Address **4234 Manchester**
19. (a) **MAY 9 1945** (b) _____
(Date received local registrar) (Registrar's signature)

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 **Edith E. Ambruster** (M. D. or other) _____
Address _____ Date signed **5/8/45**

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..... *Harvey Eynck*.....
Licensed Embalmer No. *1284*.....
P. O. Address *St Louis Mo*.....

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.