

FILED SEP 31 1945

Primary Registration District No. 1003

Registrar's No. 8072

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: City Infirmary
(d) Length of stay: In hospital or institution 2 weeks 2 days
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 12
(d) Street No. 313 A. Geyer, Ave. 923
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LONNIE EARL GIBSON

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

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced INFANT 0

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

7. Birth date of deceased May 12 1945 (Month) (Day) (Year)

8. AGE: Years 0 Months 4 Days 2 If less than one day hr. _____ min.

9. Birthplace St. Louis Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation -

11. Industry or business -

12. Name Louis O. Gibson
13. Birthplace Desloge, Mo. 0 (City, town, or county) (State or foreign country)
14. Maiden name Mabel Farmer
15. Birthplace Herculaneum Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Wm. Windsheimer
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof Sept 17/45 (Month) (Day) (Year)
(c) Place: burial or cremation Park Lawn Cem

18. (a) Signature of funeral director Thos. A. ...
(b) Address 3996 Gravois Ave.

19. (a) SEP 10 1945 (b) J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 14th; year 1945 hour 10:15 P. M. minute _____ M.

21. I hereby certify that I attended the deceased from August the 29th; 19 45 to September 14, 19 45 that I last saw him alive on September 14, 19 45 and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple Congenital Deformities, Fontanel, Spina Bifida, Due to Marrocephalic.

Due to 157-15
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) _____
23. Signature Sakun P. ... (M. D. or other) _____
Address 5800 Arsenal Date sign 15/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10
17
9

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.....

David Van Fossan

Licensed Embalmer No. *4242*

P. O. Address. *2906 Harris Ave*

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.