

Registration District No. **APR 7 1946**

Primary Registration District No. **6076**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **Jefferson Barracks**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Since 2/19/46**
(Specify whether
 In this community **4 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **63**
 (c) City or town **Belle** **0**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Star Route** **0**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **1**
 If yes, name country _____

3. (a) PRINT FULL NAME **GILBY, Bertram O.**

3. (b) If veteran, name war **World I**
 3. (c) Social Security No. **486140871**

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

6. (b) Name of husband or wife **Rose Gilby**

6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **January 21 1890**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 1 27 hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **William Gilby**

13. Birthplace **England** **4**

14. Maiden name **Sophia Solomon** **4**

15. Birthplace **England** **4**

16. (a) Informant **Clinical Clerk Vet. Adm. Hosp.**

(b) Address **Jefferson Barracks, Missouri**

17. (a) **Removal** (b) Date thereof **March 21, 1946**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belle, Missouri.**

18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**

(b) Address **7814 S. Broadway St. Louis, Mo.**

19. (a) **3/23/46** (b) **P. G. ...**

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20**
 year **1946** hour **2:30** minute **A** M.

21. I hereby certify that I attended the deceased from **2/19/46**, 19___, to **3/20/46**, 19___;
 that I last saw him alive on **March 20**, 19___
 and that death occurred on the date and hour stated above.

Immediate cause of death **BRONCHO PNEUMONIA**

WITH EFFUSION

Due to **107**

Due to _____

Other conditions **PEPTIC ULCER**

(Include pregnancy within 3 months of death)

Major findings: **No Operation**

Of operations _____

Of autopsy **No Autopsy**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work? **0** (Specify type of place) (c) Means of injury **0**

23. Signature **L. E. STILWELL, M.D.** (M. D. or other)

Address **Vet. Adm. Hosp. Jeff. Brks., Mo.** Date signed **3/20/46**

Duration

UNK

UNK

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

9660

oil

APR 5 1954

APR 7 1954

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 *Linus C. Hoffmeister*.....

Licensed Embalmer No. *3871*.....

P. O. Address *7814 S Broadway*.....

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.