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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

LED DEC 2 1946 318

Primary Registration District No. 1003

Registrar's No. 9895

1. PLACE OF DEATH:

(a) County ST LOUIS MO

(b) City or town ST LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: CITY HOSP
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 WEEKS
(Specify whether years, months or days)

In this community 10 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____

(c) City or town ST LOUIS MO
(If outside city or town limits, write "RURAL")

(d) Street No. 4719 WASHINGTON BLDG
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME LAURA ELLEN GANTZ

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife AUGUST T GANTZ

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

7. Birth date of deceased JUNE 27 1871
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 22 If less than one day 6 hr. 10 min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER

12. Name FRANKLIN P BURKE

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

14. Maiden name KATHERINE KEENER

15. Birthplace PENN
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. [unclear]

(b) Address 1136 [unclear] Dr

17. (a) BURIAL (b) Date thereof NOV 22 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STEWARTSVILLE MO

18. (a) Signature of funeral director Walter [unclear]

(b) Address 6536 Clayton Rd

19. (a) NOV 20 1946 (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19
year 1946 hour 6 minute 05 a. M.

21. I hereby certify that I attended the deceased from 21 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 Fractured left hip
intercurrent when he slipped
and fell while working in the
garage Oct. 29 1946 about
9:00 p.m.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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) Accident

(b) Date of occurrence Oct 29 1946

(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?
None

While at work? (Specify type of place)

(e) Means of injury

23. Signature John G. [unclear] (M.D. or other)

Address Date signed 11/20/46

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

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

J. Allen Davis Jr

Licensed Embalmer No..... *4053*

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.