

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **18858**
Registrar's No. **5166**

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DePaul Hospital
(If not in hospital or institution, write street number or location)
(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**
(If outside city or town limits, write "RURAL")
(d) Street No..... **5461 Arlington Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Nora Hazel Gielow**
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced... **married**
6. (b) Name of husband or wife..... **Oliver W. Gielow** 6. (c) Age of husband or wife if alive..... **53** years
7. Birth date of deceased..... **11 13 1893**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 6 10 hr. min.

9. Birthplace..... **Owensville, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Housewife**

11. Industry or business.....

12. Name..... **William F. Poppenhouse**

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

14. Maiden name..... **Lucretia Ager**

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

16. (a) Informant..... **Mr. Oliver W. Gielow**

(b) Address..... **5461 Arlington Ave.**

17. (a) **burial** (b) Date thereof..... **5/26/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Lake Charles**

18. (a) Signature of funeral director..... **Drehmann-Harral**

(b) Address..... **1905 Union Blvd.**

19. (a) **MAY 23 1947** (b) **J. G. Brebeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... **May** day..... **23**
year..... **1947** hour..... **1:40** minute..... **A.M.**

21. I hereby certify that I attended the deceased from..... **5:30 P.M.**
May 22, 1947, to..... **1:40 May 23**, 1947,
that I last saw him..... alive on..... **May 22**, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebral Hemorrhage 9 hrs
Due to..... **Hypertensive**
Due to..... **Cardio-vascular**
Disease
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause of 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..... (Specify) Means of injury.....

23. Signature..... **John F. Shaner** (M. D. or other).....
Address..... **607 N. Grand** Date signed..... **23 May 1947**

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

MOTHER FATHER

500
17
9
5

93

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..... *Albert R. Thompson Jr*
Licensed Embalmer No. *4237*
P. O. Address *St Louis*

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.