No. 2
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17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 21 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29049

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7514

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

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: St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. #4910 Goodfellow
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ISABEL COOPER GAMEWELL.

3. (b) If veteran, name war NO — 3. (c) Social Security No. NO

4. Sex FEMALE — 5. Color or race WHITE — 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased NOVEMBER (Month) 10 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
71	8	27	hr. min.

9. Birthplace Cameden, (City, town, or county) So. Carolina (State or foreign country)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name Phineas Thornton Gamewell.
13. Birthplace Cameden, (City, town, or county) So. Carolina (State or foreign country)

MOTHER
14. Maiden name Isabel Gardiner Cooper
15. Birthplace Cameden, (City, town, or county) So. Carolina (State or foreign country)

16. (a) Informant Sadie T. Gamewell.
(b) Address 910 Goodfellow,

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-9-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Crematory

18. (a) Signature of funeral director C.R.Lupton & Sons.
(b) Address 7233 Delmar Blvd.,

19. (a) AUG 9 1947 (Date received local registrar) (b) J.F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 7 year 1947 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from July 29 1947 to Aug. 7 1947 that I last saw her alive on Aug. 7 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	2 days
Due to: Arteriosclerosis - by pas tension - heart ex haustion	many years
Due to	
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? (e) Means of injury

23. Signature Frances R. Ritchie (M. D. or other) M. D.
Address 5233 Westmoreland Date signed 8.8.47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

5233 Waterman
FO 5071

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 Raymond L. Morris

Licensed Embalmer No. 4330

P. O. Address Maplewood, M

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.