No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29054

FILED SEP 8 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8347

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: 1303 Grattan St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 21 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 22 1303 Grattan St. 9
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME JOHN JAMES GAYNOR

3. (b) If veteran, name war no

3. (c) Social Security No. 493-05-7920

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Eva Gaynor

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased October 5, 1895
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
51	10	24	hr. min.

9. Birthplace Indianapolis, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business City of St. Louis

FATHER
12. Name John J. Gaynor
13. Birthplace Massachusetts
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Murphy
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Eva Gaynor
(b) Address 1303 Grattan St.

17. (a) Burial (b) Date thereof 9-2-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave.

19. (a) SEP 2 1947 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29th
year 1947 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from August 26, 1947 to Aug 29, 1947
that I last saw him alive on Aug 28, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to cardio-renal syndrome

Due to ?

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 2

23. Signature S. J. Trafilletti (M.D. or other)

Address 1800 S. Lafayette Date signed 8/2/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JUN 1 0 1943

Dr.S.J. Trefiletti
1800a Lafayette Ave
GRand 9109

NOV 8 1957

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.....C W Cooper.....

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.