

FILED OCT 30 1947

Registration District No. 174

Primary Registration District No. 3035

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution 14th & Chestnut  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Septima  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Festungton  
(If outside city or town limits, write "RURAL")

(d) Street No. 14th & Chestnut  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jacob Gilmore

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Jan infer 1876  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Business

11. Industry or business Business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ray Bellme

(b) Address 424 Chestnut, St. Louis, Mo

17. (a) Burial (b) Date thereof 10/15/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2nd  
47 year 6 hour 100 P minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 28 Sept 47  
one visit \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on 28 Sept 47, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 Mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 37  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

23. Signature W. W. Ward MD (M. D. or other) \_\_\_\_\_

Address Festungton Mo Date signed 4 Oct 47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

pn 504

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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..... *George K. Green* .....

Licensed Embalmer No. *4230* .....

P. O. Address..... *Leedsington, N.Y.* .....

**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.