

#86665

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

20870

FILED JUL 3 1948

318

Primary Registration District No.

1003

Registrar's No.

5765

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT
FULL NAME

JESSE GAW

3. (b) If veteran,
name war3. (c) Social Security No.
492-09-6091

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married
0 divorced Widowed
 6. (b) Name of husband or wife Nellie 6. (c) Age of husband or wife if
 alive years
 7. Birth date of deceased April 27, 1883
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 1 8 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

MOTHER FATHER { 12. Name John Henry Gaw
 { 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Polly Waters
 { 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Ester Rascher
 (b) Address 5839 W. Park Ave.
 17. (a) Burial (b) Date thereof 6-29-1948
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Jay B. Smith
 (b) Address 7456 Manchester Rd.
 19. (a) JUN 28 1948 (b) J. F. Bredeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County for
 (c) City or town St. Louis 17
 (If outside city or town limits, write "RURAL") 9
 (d) Street No. 1926 Mallinkrodt St.
Memorial 26 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No) 0
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th
 year 1948 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from 6/10/48
 _____, 19____, to June 25th, 1948
 that I last saw h im alive on June 25th, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis
for advanced
 Duration long
standby

Due to

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 sta-
 tistically.

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? (d) Means of injury
 23. Signature Wm J. Johnson me D.
1515 Lafayette 6/25/48
 Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK

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. H. Burgess*.....
Licensed Embalmer No..... *4029*.....
P. O. Address..... *Maplewood*.....

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.