

X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43687

FILED JAN 3 1944

Primary Registration District No. 3070

Registrar's No. 2911

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town WEAVER GROVES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ST LOUIS
(c) City or town WEAVER GROVES
(If outside city or town limits, write "RURAL")
(d) Street No. 8 So. Old Orchard Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AMY C. GAMMONS

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife ROBERT PETER GAMMONS 6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased Nov 13 1891
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 11 If less than one day
hr. min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER
12. Name UNKNOWN UNKNOWN
13. Birthplace " " 9
(City, town, or county) (State or foreign country)
14. Maiden name " " 9
15. Birthplace " " 9
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Gammons
(b) Address 8 So. Old Orchard Ave

17. (a) BURIAL (b) Date thereof 17-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RICHLAND, MO.

18. (a) Signature of funeral director MITTELBERG FUNERAL HOME
(b) Address WEAVER GROVES, MO.

19. (a) DEC 27 1943 (b) C. H. Mc Laron, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1943 hour 6 minute 20 A.M.
21. I hereby certify that I attended the deceased from Dec 1
1941 to Dec 24 1943
that I last saw her alive on Dec 24 - 1943 19
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 1 hour
Due to Arterial Hypertension 2 yrs.
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy J. J. J.
PHYSICIAN _____
Underline the cause to 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? _____

inc. While at work? _____ (Specify type of place) (e) Means of injury Other
23. Signature Joseph Mc Neaney, M.D. (M.D. or other)
Address 2640 Brentwood Pl State signed _____

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

26
9
4

JAN 18 1944

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 John M. Meyer
Licensed Embalmer No. 3288
P. O. Address Wickwood, Ind.

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.