No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1947

Registration District No. 317

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 33290

Registrar's No. 2035

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 165 days (Specify whether In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4115 Taft (If rural, give location) 9

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Gartner, Elizabeth

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John Gartner

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased August (Month) 3 (Day) 1890 (Year)

8. AGE: Years 57 Months 1 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Schaeffer
13. Birthplace (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Katherine Vetter
15. Birthplace (City, town, or county) Germany (State or foreign country) 4

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director Zeagoshem Bros

(b) Address 6405 Gravois Ave

19. (a) 10-2-47 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 30 year 1947 hour 10 minute 35 A. M.

21. I hereby certify that I attended the deceased from 4-18, 1947 to 9-30-, 1947 that I last saw her alive on 9-30-, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	18 mo. (?)
Due to 13 G	
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) 0

While at work? (e) Means of injury

23. Signature William A. Turner (M. D. or other) MD

Address Robert Koch Hospital Date signed 9-30-47

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

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 Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address.....

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.