

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1106

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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) Koch (rural)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 185 days		d. STREET ADDRESS (If rural, give location) 3526a Cozens	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			

3. NAME OF DECEASED (Type or Print) Margaret	a. (First)	b. (Middle)	c. (Last) Gustavis	4. DATE OF DEATH May 2, 1949
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 1-26-04	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hazelhurst, Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles Gustavis	13b. MOTHER'S MAIDEN NAME Mariah Chatman	14. NAME OF HUSBAND OR WIFE Archie Adams (deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. 492-03-4683	17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Robt. Koch Hosp.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ???
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		113 1/2	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 102X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10-29-1948, to 5-2-1949, that I last saw the deceased alive on 5-2-1949, and that death occurred at 1:20A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. W. Beckman, M.D.	23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 5-2-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-9-49	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	24d. LOCATION (City, town, or county) (State) Lemay, Missouri
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DATE REC'D BY LOCAL REG. 5-4-49	REGISTRAR'S SIGNATURE Theresa L. ...	25. FUNERAL DIRECTOR'S SIGNATURE L. B. ...	ADDRESS 1221 N. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Jeoffine C. Cooper

Licensed Embalmer No. 4600

P. O. Address 1231 E. Strand

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.