

FILED JUN 8 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17512

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 300	Registrar's No. 1276
1. PLACE OF DEATH a. COUNTY SAINT 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) OR TOWN OLIVETTE:		c. LENGTH OF STAY (in this place) 1 1/2 YRS	c. CITY OR TOWN OLIVETTE	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BONHOMME RESTORIIUM:		e. STREET ADDRESS (If rural, give location) 9564 OLD BONHOMME ROAD.		
3. NAME OF DECEASED (Type or Print) S O P H I E		a. (First)	b. (Middle) ---	c. (Last) G A U G E R
4. DATE OF DEATH JUNE 1, 1954.		5. SEX FEMALE		6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH JAN'Y 7 1865.		9. AGE (In years last birthday) 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and State or Foreign Country) SAINT LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME JACOB GAUGER		
13b. MOTHER'S MARDEN NAME UNK STIFEL		14. NAME OF HUSBAND OR WIFE AGNE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME OTTO CONRADES
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Arteriosclerotic Heart Disease  DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Death  Several Years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 4200
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from March, 1951, to June 1, 1954, that I last saw the deceased alive on about May 15, 1954, and that death occurred at 12:30 p.m., from the causes and on the date stated above.				
23a. SIGNATURE Arnold S. Klein M.D.		23b. ADDRESS 2632 Kings Highway		23c. DATE SIGNED June 1, 1954
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JUNE 2 1954		24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEMETERY
24d. LOCATION (City, town, or county) SAINT LOUIS, MO.		24e. (State)		
DATE REC'D BY LOCAL REG. 6/2/54		REGISTRAR'S SIGNATURE Herbert R. Ambrose		25. FUNERAL DIRECTOR'S SIGNATURE C. R. LUPTON & SONS
		ADDRESS 7233 DELMAR BLV'D.		

**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.....  
Signature of Student Embalmer

Signed.....  
*Clarence A. Murray*

Licensed Embalmer No. *401*  
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.