

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24557**
Registrar's No. **7153**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

4

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

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| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 7153 | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) 2 Days | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Bernard Nursing Home | | | | e. STREET ADDRESS (If rural, give location) 4942 West Pine Blvd 2129 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Addie | | b. (Middle) M. | | c. (Last) Gatz | | 4. DATE OF DEATH (Month) (Day) (Year) July 31, 1954 | |
| 5. SEX F. | | 6. COLOR OR RACE W. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | | 8. DATE OF BIRTH April 24, 1875 | |
| 9. AGE (In years last birthday) 79 | | IF UNDER 1 YEAR Months | | IF UNDER 1 YEAR Days | | IF UNDER 1 YEAR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Saleslady | | 11. BIRTHPLACE (City and State or Foreign Country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME Alois Gatz | | 13b. MOTHER'S MAIDEN NAME Mary Wolf | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 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. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Addie M. Gatz 4942 West Pine Bl | | | |
| 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) Cerebral Haemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial changes | | | | INTERVAL BETWEEN ONSET AND DEATH 5 weeks 1 yr + 2 yr + 9 yr + | |
| 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) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 331X | | | | 22. I hereby certify that I attended the deceased from June 23, 1954 , to July 31, 1954 , that I last saw the deceased alive on July 31, 1954 , and that death occurred at 11:00 P.m. , from the causes and on the date stated above. | |
| 23a. SIGNATURE (Degree or title) W. H. ... M.D. | | 23b. ADDRESS 1117 N. ... | | 23. DATE SIGNED Aug 25 54 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Aug. 3, 1954 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| DATE REC'D BY LOCAL REG. AUG 2 1954 | | REGISTRAR'S SIGNATURE Carl Smith, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly | | ADDRESS 3840 ... | |

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 *Francis Williams*

Licensed Embalmer No. *356*

P. O. Address *3840 Lyn*

**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.**