

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **44826**  
Registrar's No. **12045**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>12045</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>1 Hour</b>		c. CITY OR TOWN <b>4150 Arbor Terrace C</b>		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 <b>New Faith Hospital</b>				STREET ADDRESS (If rural, give location) <b>3741 Melba</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>LOUISE</b>		b. (Middle) <b>MARGARET</b>		c. (Last) <b>GUSKY</b>	
4. DATE OF DEATH		(Month) <b>Dec.</b>		(Day) <b>30,</b>		(Year) <b>1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Apr. 20, 1892</b>	
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home maker</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Benld Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Paul Schultz</b>		13b. MOTHER'S MAIDEN NAME <b>Fredrica Gordes</b>		14. NAME OF HUSBAND OR WIFE <b>William Gusky</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Ralph W. Gusky</b> ADDRESS <b>3741 Melba Pl.</b>			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary heart disease</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>40 min</b> <b>5 yrs</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input 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? _____			
22. I hereby certify that I attended the deceased from <b>Jan 1949</b> , to <b>Nov 15, 1956</b> , that I last saw the deceased alive on <b>Nov 15, 1956</b> , and that death occurred at <b>9:20 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Anthony V. Benincasa MD</b>				23b. ADDRESS <b>3731 Goodfellow Blvd</b>		23c. DATE SIGNED <b>12-30-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Jan. 2, 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Stanton Memorial Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Stanton, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 31 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullen Kelly</b>		ADDRESS <b>7267 Natural Bridge</b>	

*Bevinca*  
*3731*

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 *James A. Lamme*

Licensed Embalmer No. *414*  
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.