

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26125

FILED JUL 26 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6264**

Health, Welfare  
Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>21 3411 UTAH</b> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>2167 3411 UTAH</b> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES C. GAUBATZ</b> First Middle Last			4. DATE OF DEATH <b>JULY 3 1957</b> Month Day Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 4 1885</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BAKER</b>		9b. AGE (In years last birthday) <b>72</b>	9c. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE GAUBATZ</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>OLIVIA A. GAUBATZ</b> Address <b>3411 UTAH</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>332x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>27 months</b> <b>2 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>Mar. 5, 1957</b> and last saw him alive on <b>July 3, 1957</b> Death occurred at <b>9 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M. R. Walucka M.D.</b> (Degree or title)		22b. ADDRESS <b>8916 Gravois</b>	22c. DATE SIGNED <b>7-5-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>JULY 6 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S.S. PETER &amp; PAUL</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, Mo</b>
24. FUNERAL DIRECTOR <b>Thomas Peter 2906 Gravois</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUL 5 57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>

(Licensed Embalmer's Statement on Reverse Side)

HO 1-2999

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed.....  
*Leo Budd*  
Licensed Embalmer No. 3

P. O. Address.....  
*H. Lewis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.