

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016684

STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1209

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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 Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Richmond Heights Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hosp.		Length of stay in lb DOA	d. STREET ADDRESS (If outside, give location) 7240 Glades Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle GINTEL Last			4. DATE OF DEATH Month May Day 1 Year 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1878	9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Service	10b. KIND OF BUSINESS OR INDUSTRY Gov't.	11. BIRTHPLACE (City and state or country) Austria	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Meyer Gintel	13b. MOTHER'S MAIDEN NAME Anna (unk)	14. NAME OF HUSBAND OR WIFE Dora
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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. 488-03-5951	17. INFORMANT Charles Gintel 5442a Morganford Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO (b) Chr. Myocarditis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Primary Pernicious Anemia 4331		INTERVAL BETWEEN ONSET AND DEATH Immediate 1953
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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.)
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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
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21. I attended the deceased from **February 1946** to **death** and last saw him alive on **April 29-1958**
Death occurred at _____ m on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE Wesley P. Drake (Degree or title) M.D.	22b. ADDRESS 8505 Delmar Blvd. 29	22c. DATE SIGNED 5-2-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Bur.	23b. DATE 5/4/58	23c. NAME OF CEMETERY OR CREMATORY Chevre Kadisha	23d. LOCATION (City, town, or county) (State) University City, Mo.
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24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson ADDRESS	25. DATE RECD. BY LOCAL REG. 5-5-58	26. REGISTRAR'S SIGNATURE Wesley P. Drake M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 27 1959

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 

Licensed Embalmer No. 4229

P. O. Address

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.