

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010925  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **3071**

**FILED APR 10 1959**

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, give TOWNSHIP only) Inside Limits  
OR TOWN **St. Louis** Yes  No

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb  
HOSPITAL OR INSTITUTION **Enroute City Hospital**

d. STREET ADDRESS (If outside, give location) Reside on Farm  
**5721 Rosa Ave.** Yes  No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year  
**MICHAEL S. GAHN** **Mar. 26 1959**

5. SEX 6. COLOR OR RACE 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  
**Male** **White** **WIDOWED** **DIVORCED** **Jan. 15, 1959** **0** **2** **2** **0** **0** **0** **0**

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) 12. CITIZEN OF WHAT COUNTRY?  
**None** **None** **St. Louis, Mo.** **U.S.A.**

13a. FATHER'S NAME 13b. MOTHER'S MAIDEN NAME 14. NAME OF HUSBAND OR WIFE  
**William J. Gahn** **Virginia J. Thornhill** \_\_\_\_\_

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address  
**No** **None** **None** **William J. Gahn 5721 Rosa Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY: **Interstitial Pneumonitis**  
IMMEDIATE CAUSE (a) \_\_\_\_\_  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_ **525X**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) \_\_\_\_\_  
INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

19. WAS AUTOPSY PERFORMED?  
YES  NO

20a. ACCIDENT SUICIDE HOMICIDE

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  NOT WHILE AT WORK

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 \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at **645 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) 22b. ADDRESS 22c. DATE SIGNED  
**Satriet Taylor Corcoran** **1300 Clark** **3.26.59**

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)  
**Removal** **Mar. 28, 1959** **Resurrection Cemetery** **St. Louis Co. Mo.**

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE  
**Kriegshauser 4228 S. Kingshighway** **MAR 26 '59** **Leah Smith, M.D.**

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*mrc*

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 *William B White* .....

Licensed Embalmer No. *5291* .....  
P. O. Address *2284 Kingsley* .....

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.