

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022920

STATE FILE NUMBER

6180

FILED JUL 13 1959

Registration District No. Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Booth Memorial Hosp.</u>		Length of stay in lb <u>3 Days</u>	d. STREET ADDRESS (If outside, give location) <u>5504 Pennsylvania ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Gmerek</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1896</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13a. FATHER'S NAME <u>Fred Funk</u>		13b. MOTHER'S MAIDEN NAME last name <u>Elizabeth Susan Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Edward A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>494-05-3479 E</u>	17. INFORMANT Address <u>Lawrence Gmerek 10075 Monarch Dr. St. Louis 17</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>			<u>12 years</u>
		DUE TO (c) <u>Hepatic Cirrhosis & ascites</u>			<u>1 year 1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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 <u>Jan 10 1957</u> to <u>June 27 '59</u> and last saw her alive on <u>6/27/59</u> Death occurred at <u>4:06 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Michael L. Bartnick M.D.</u>		22b. ADDRESS <u>7615 So Broadway</u>		22c. DATE SIGNED <u>6/29/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Watson & McKenzie Rd.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7814 S. Broadway</u>			25. DATE RECD. BY LOCAL REG. <u>JUN 30 '59</u>		26. REGISTRAR'S SIGNATURE <u>Kear Smith. M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Bill C. Branson*

Licensed Embalmer No. *4764*

P. O. Address *St. Louis, Mo.*

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.