

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026659

FILED VS AUG 4 1959

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4530a Red Bud Avenue, 15 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DOROTHY Middle ELIZABETH Last GAEBLER			4. DATE OF DEATH Month July Day 21st Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-2-90	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY Board of Education	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Robert Charles Gaebler	13b. MOTHER'S MAIDEN NAME Elizabeth Kramrey	14. NAME OF HUSBAND OR WIFE None
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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. None	17. INFORMANT Olga E. Gaebler, 4530a Red Bud Avenue.	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:		INTERVAL BETWEEN ONSET AND DEATH 6 days
IMMEDIATE CAUSE (a)	post operative effects	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) RT Hemiselectomy	
	DUE TO (c) Ca of ascending colon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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 **4-4-49** to **7-21-59** and last saw her **alive** on **7-21-59**
Death occurred at **12:32 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title)	22b. ADDRESS 4110 W Florissant Ave	22c. DATE SIGNED 7-22-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-25-59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Calvin F. Feutz, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri.	25. DATE RECD. BY LOCAL REG. JUL 23 '59	26. REGISTRAR'S SIGNATURE [Signature]
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

7/18/59

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed John A. Miller

Licensed Embalmer No. 4186

P. O. Address St. Louis 3

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.