RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

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FILED VS MAY 25 1960

DED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5145 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis City Hosp. # 1
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis.
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2008 (rear) Franklin
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: NICHOLAS GUST (also known as) GUST NICKLAS

4. DATE OF DEATH Month Day Year: May 12 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Dishwasker
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (City and state or country): Lutro Edipho Evias, Greece
12. CITIZEN OF WHAT COUNTRY: ?

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE:

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.: 488-30-3403
17. INFORMANT: Sam Nols, 2008 (rear) Franklin, Ave.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO (b): Acute Myocardial Infarction
DUE TO (c): Coronary Atherosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pleural Effusion (Bilateral)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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.) 420.1
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ 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 5/9/60, to 5/12/60 and last saw ~~her~~ him alive on 5/12/60
Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert Stein, MD (Degree or title)
22b. ADDRESS: 1515 Lafayette Ave.
22c. DATE SIGNED: 5/13/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-16-60
23c. NAME OF CEMETERY OR CREMATORY: St. Matthews Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe Inc., 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG.: MAY 16 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.
M.D.C.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No.

P. O. Address

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