

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021883

FILED VS MAY 31 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500.590 Registrar's No. 1656

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Florissant</b>		Length of stay in 1b <b>7 yrs</b>	c. CITY OR TOWN <b>Florissant</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>700 Lindsay Lane</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>700 Lindsay Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>FRED</b> Last <b>GAZDA</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1960</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-1908</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Blackwell-Wielandy (off. &amp; paper supply)</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Joseph Gazda</b>	13b. MOTHER'S MAIDEN NAME <b>Helen Himmelsbach</b>	14. NAME OF HUSBAND OR WIFE <b>Marie Trapp Gazda</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>497-0909245</b>	17. INFORMANT <b>Marie Gazda, 700 Lindsay Lane, Florissant, Mo.</b>
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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
IMMEDIATE CAUSE (a)	<b>Medullary paralysis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral anoxia</b>	<b>48 hrs</b>
	DUE TO (c) <b>Congestive Heart Failure</b>	<b>months</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Cor Pulmonale</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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 1957 to 1960 and last saw her/him alive on May 19, 1960.  
Death occurred at P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>Paul S. Moore, D.O.</b>	22b. ADDRESS <b>833a Jennings 20 St. Louis 36</b>	22c. DATE SIGNED <b>5-24-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-25-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ferdinand Cemetery</b>	23d. LOCATION (City, town, or county) <b>Florissant, Mo.</b>
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24. FUNERAL DIRECTOR <b>The Florissant Mortuary, Florissant, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-24-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Gene A. Hutchens

Licensed Embalmer No. 4966

P. O. Address Florissant, Mo.

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