

318

1003

4459

AMENDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

FILED MAY 19 1961

| | | | | | |
|--|---|---|--|--|---|
| 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) OR TOWN St. Louis, Missouri | | Length of stay in 1b 39 yrs. 2 mo. | 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 St. Louis State Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1735 Hoehn St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ELIZABETH Middle GASPER Last | | | 4. DATE OF DEATH Month May Day 9th, Year 1961 | | |
| 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 11-1-89 | 9. AGE (last birthday) 71 yrs. | 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) Nil | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Thraconista, Bohemia | 12. CITIZEN OF WHAT COUNTRY Alien | |
| 13a. FATHER'S NAME Frank Gasper | | 13b. MOTHER'S MAIDEN NAME Julia ? | | 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. | 17. INFORMANT Address Pauline Cebak 4128 S Compton Av | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) Conjestive Heart Failure | | | | | |
| DUE TO (c) Arteriosclerotic Heart Disease 4200 | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple pulmonary infarcts, bilateral, old | | | | | 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.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | | | |
| 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 | |
| 21. I attended the deceased from March 9, 1922 to May 9, 1961 and last saw her/him alive on May 9, 1961 Death occurred at 10:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>L. N. W. Cullough M.D.</i> (Degree or title) | | | 22b. ADDRESS 5400 Arsenal St. | | 22c. DATE SIGNED 5-10-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/12/61 | 23c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem | | 23d. LOCATION (City, town, or county) St. Louis Missouri | (State) |
| 24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen | | 25. DATE RECD. BY LOCAL REG. MAY 11 1961 | 26. REGISTRAR'S SIGNATURE <i>Leard Smith, M.D.</i> | | |

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Harley R. Joellen Jr
Licensed Embalmer No. 4950

P. O. Address St. Louis

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.