

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-035271
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2396

1. PLACE OF DEATH
 a. COUNTY **St. Louis,**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Richmond Heights,** Length of stay in 1b **DAYS**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St Marys Hosp.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo.** b. COUNTY **St. Louis,** Inside Limits Yes No
 c. CITY OR TOWN **St. Louis,**
 d. STREET ADDRESS (If outside, give location) **5062a Pernod Ave.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **MARGARET** Middle Last **GANTNER** 4. DATE OF DEATH Month **Aug.** Day **24th** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9-19-1901** 9. AGE (last birthday) **60** IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Home** 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **James Shields** 13b. MOTHER'S MAIDEN NAME **Mary Wills** 14. NAME OF HUSBAND OR WIFE **Bert L. Gantner**

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. **904.0-21** 17. INFORMANT Address **Mrs. Thomas A. Hogan-5062a Pernod Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Subdural hemelomata**
 DUE TO (b) **Trauma - a fall.**
 DUE TO (c) **Accident - Epilepsy? Br. Tumor?**
 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.
 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.)
Fall on her face at home

20c. TIME OF INJURY Hour **8** Month, Day, Year **3.61**
 a.m. p.m.

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.) **at home** 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **8-3-61** to **Aug 24/61** and last saw her alive on **Aug 23-1961**
 Death occurred at **9:25 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **M. Kusella M D** (Degree or title) 22b. ADDRESS **3720 Washington** 22c. DATE SIGNED **8/25/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Aug. 26, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Resurrection** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Kriegshauser-4228 S. Kingshighway Blvd.** 25. DATE RECD. BY LOCAL REG. **8-25-61** 26. REGISTRAR'S SIGNATURE **John B. Murphy M.D.**

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 *R. W. Stovreand*

Licensed Embalmer No. 4007

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.