

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041018

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2930

FILED OCT 26 1962

VS 300 Rev. 4/59	1400	24000	3	4 0	5 2	6	7 2	8 0	94222	10	11	1286-0	13
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS													
INSTEAD OF													
SHOULD READ													
ITEM NO.													
BY AFFIDAVIT OF													

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KEETON</u>		Length of stay in 1b <u>3 WKS</u>		c. CITY OR TOWN <u>MEHLVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) <u>MILLER Nur. Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7205 So LINDBERGH</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARCUS — GERSTNER</u>				4. DATE OF DEATH Month Day Year <u>OCT - 7 - 1962</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-12-1877</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>5 26</u>		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BAKING</u>		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>					
13a. FATHER'S NAME <u>JOSEPH GERSTNER</u>				13b. MOTHER'S MAIDEN NAME <u>MONICA P</u>		14. NAME OF HUSBAND OR WIFE <u>MARY GERSTNER</u> <u>SECOND</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NIL NIL</u>				16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>7205 So LINDBERGH</u> <u>S FRANCES GERSTNER ST LOUIS MO</u>							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis, chronic</u>										INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchial asthma</u>										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			
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.)									
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 <u>9-4-62</u> to <u>10-7-62</u> and last saw <sup>her</sup> him alive on <u>10-4-62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>M. K. Walencki MD</u>						22b. ADDRESS <u>8916 22nd Ave</u>				22c. DATE SIGNED <u>10-8-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE <u>OCT-11-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SS. PETER &amp; PAUL Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>				
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE MO</u>						25. DATE RECD. BY LOCAL REG. <u>10-10-62</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>					

USE BLACK INK OR TYPEWRITER RIBBON

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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Gustav W. Dietel*

Licensed Embalmer No. \_\_\_\_\_

*4329*

P. O. Address \_\_\_\_\_

*St Louis Mo*

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.