

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE XC-1715 342

SL 13394

-63-013323

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2819

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 20 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>210 N. Sarah</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>A.</u> Last <u>GUSTIN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cincinnati, Ohio</u>
13a. FATHER'S NAME <u>William Gustin</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-1</u>		17. INFORMANT <u>Bessie Gustin (Wife), Same add. as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u> DUE TO (b) <u>451X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
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.)	
21. attended the deceased from <u>3/9/63</u> to <u>3/10/63</u> and last saw him alive on <u>3/10/63</u> Death occurred at <u>4:45 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. NIDELMAN M.D.</u> (Degree or title)		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	
22c. DATE SIGNED <u>3/10/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-13-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery, J.B. Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>	
24. FUNERAL DIRECTOR <u>Arthur J. Kennell</u> ADDRESS <u>3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 11 1963</u>	
		26. REGISTRAR'S SIGNATURE <u>Loard Smith M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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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 _____

Licensed Embalmer No. 4699

P. O. Address 3840 Fondell

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.