

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045511

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12096

STATE FILE NUMBER

FILED DEC 12 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 Weeks 1 Da	c. CITY OR TOWN St. Louis
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location). 6027 Thekla
3. NAME OF DECEASED (Type or print) Carrie Belle Gustafson		4. DATE OF DEATH December 6, 1963	

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1887	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MUNCIE INDIANA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME OLIVER BURTON			13b. MOTHER'S MAIDEN NAME MARHA UNKNOWN		14. NAME OF HUSBAND OR WIFE Carl		

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.		17. INFORMANT CARL GUSTAFSON		Address	
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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: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE			INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE			
DUE TO (c) 4200			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CEREBRAL ARTERIOSCLEROSIS, DIABETES MELLITUS			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	
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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.)	
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	
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21. I attended the deceased from **November 16, 1963** to **December 6, 1963** and last saw ^{her} _{him} alive on **December 6**
Death occurred at **10:45A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>		(Degree or title) M.D.		22b. ADDRESS 1755 SO GRAND ST LOUIS MO		22c. DATE SIGNED 12-7-63	
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 12/9/63		23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Ceme.		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
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24. FUNERAL DIRECTOR John Styger & Son 5541 Riverview Boulevard			ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 7 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1
 2 **207**
 3
 4 **1**
 5 **1**
 6
 7 **1**
 8 **1**
 9
 10
 11
 12 **69-0**
 13
 69
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

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,

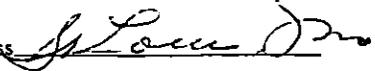
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. _____

P. O. Address  _____

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.