

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41145
State File No. _____
Registrar's No. **10268**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

2

(a) County _____
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2124 South Grand Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

1

(a) State Missouri (b) County _____
(c) City or town 2124 South Grand Blvd. 17
(If outside city or town limits, write "RURAL")
(d) Street No. Saint Louis, Missouri
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Dr. August T. Gast. 230

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May
(Month)

8th, 1881.
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

58

6

20

hr. _____ min.

9. Birthplace St. Louis, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist.

11. Industry or business _____

12. Name Renatius C. Gast.

18. Birthplace Saint Louis, Missouri.
(City, town, or county) (State or foreign country)

14. Maiden name Elisa Fahey

15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ben Gast

(b) Address 2124 South Grand Blvd.

17. (a) Burial (b) Date thereof Dec. 1st, 39.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park.

18. (a) Signature of funeral director Zigankens Bros.

(b) Address 2623 Cherokee Street.

19. (a) DEC 1 1939
(Date registered) (Local registrar's signature)

J. J. Brudish
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28th,
year 1939. hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from May
1939 to Nov 9, 1939;
that I last saw him alive on Nov 7, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 30 min

Due to Chr Hypertension 1 yr

Due to Chr nephritis 1 yr

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. M. Brand (M. D. or other)

Address 3651 Grand Date signed Nov 29

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed W E Morris

Licensed Embalmer No. 3360

P. O. Address 2123 Cherokee

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 this body is not embalmed, above space should be left blank.