

LED JUL 24 1943

Registration District No. 217

Primary Registration District No. 3068

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Maplewood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3429 Manhattan Avenue /  
(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)

3. (a) PRINT FULL NAME Callie B. Gaston

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John W. Gaston 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased October 9, 1857  
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Urbana Ohio /  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name David R. Baker 13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Susan E. Taylor 15. Birthplace Kentucky /  
(City, town, or county) (State or foreign country)

16. (a) Informant Renee F. Gaston  
(b) Address 3429 Manhattan Avenue.

17. (a) Burial (b) Date thereof July 19, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Lebanon Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Avenue.

19. (a) JUL 20 1943 (b) J. W. Dowd, M.D.  
(Physician's signature) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Maplewood  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3429 Manhattan Avenue  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17, 1943  
year 2 hour 30 minute P. M.

21. I hereby certify that I attended the deceased from Dec 12  
1942 to July 17, 1943  
that I last saw her alive on July 17, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis

Due to arterio-sclerosis

Due to senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Missouri (M. D. or other)  
35 Cambridge Date signed 7/19/43

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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.....

.....  
working under my personal supervision.

..... Registered Apprentice No.....

Signed.....

*Albert G. Kasper*

..... Licensed Embalmer No..... 2971

..... 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 this body is not embalmed, fact should be so stated above.**