S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38483

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2708

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1136 Moorlands Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 19 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ST LOUIS 96
(c) City or town RICHMOND HTS Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1136 MOORLANDS DR 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marie Stephany Gantz

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Gordon A. Gantz

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Feb. (Month) 1st (Day) 1898 (Year)

8. AGE: Years 47 Months 9 Days 24 If less than one day 13 hr. 45 min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Beirne
13. Birthplace Unknown (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Margaret Nee
15. Birthplace Unknown (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Gordon Gantz
(b) Address 1136 Moorlands Drive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Watson Bockeye
(b) Address 6536 Clayton Rd

19. (a) 11-29-45 (Date received local registrar) (b) E G McGovern MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26
year 1945 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from
April, 1943, to Nov. 26, 1945;
that I last saw her alive on Nov. 25, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Ac. cardiac failure	one day
Due to: Hypertensive cardio-vascular disease	Uncertain
Due to: 93d	
Other conditions: none (Include pregnancy within 3 months of death)	
Major findings: Of operations: none	
Of autopsy: none	

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

23. Signature H. E. Oppenheimer, (M. D. or other) MD
Address 3720 Washington Date signed 11-27-45

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkinson

Licensed Embalmer No. 3575

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.