

FILED MAR 30 1946
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital-Max C. Starkloff**
(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 **KATIE GEHL**

3. (b) If veteran, name war **No** 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife **John Gehl** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept. 12 1864**
(Month) (Day) (Year)

8. AGE: Years **81** Months **6** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business _____

12. Name **John Luffy**

13. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

14. Maiden name **Kath Ruck**

15. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

16. (a) Informant **Math Luffy**
(b) Address **3838 Texas Ave.**

17. (a) **Burial** (b) Date thereof **3 20 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **S.S. Peter & Paul**

18. (a) Signature of funeral director **Witt Bros.**

(b) Address **2929 So. Jefferson**

19. (a) **MAR 19 1946** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **2317**
(If outside city or town limits, write "RURAL")
(d) Street No. **1845 So. 9th St. Memorial**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **17th**
year **1946** hour **10:05** minute **P** M.

21. I hereby certify that I attended the deceased from **3/3/46**
_____, 19____, to **3/17/46**, 19____.

that I last saw **her** alive on **3/17/46**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardio-vascular disease**

Due to _____

Due to _____

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

Major findings: Of operations _____

Myelopathy of the Rectal Muscles
Of autopsy **Retros. peritoneal hemorrhage**
Some undetermined

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? **Yes** (Specify type of place) _____
(If means of injury, specify) _____

23. Signature **George Park** **3/18/46**
1515 Marquette (Date signed)

Duration

PHYSICIAN

Underline cause to which death should be charged statistically.

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

MOTHER FATHER

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 me

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

Signed D. M. Davis

Licensed Embalmer No. 374

P.O. Address 2929 Jefferson

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.