

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

FILED JAN 19 1949

State File No. **2695**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **246**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>246</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS MO</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		d. STREET ADDRESS (If rural, give location) <b>6625 ALABAMA</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. ANTHONY'S Hosp.</b>				d. STREET ADDRESS (If rural, give location) <b>6625 ALABAMA</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILMA</b> b. (Middle) _____ c. (Last) <b>GASKO</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 8 1949</b>						
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 3 1884</b>		9. AGE (In years last birthday) <b>65</b>	10. MONTHS <b>-</b>	11. DAYS <b>5</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>KASPER SCHNEIDER</b>			13b. MOTHER'S MAIDEN NAME <b>MARY (UNKNOWN)</b>		14. NAME OF HUSBAND OR WIFE <b>ANTON GASKO</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MARIE GASKO 6625 ALABAMA</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Septicemia</b>				DUPLICATE OF (b) <b>Diabetic Gangrene of Foot</b>				<b>3 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUPLICATE OF (c) <b>Diabetes Mellitus</b>								<b>9 months</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pneumonia Left Lung</b>								<b>2 day</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Diabetic Gangrene of L. Foot</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from _____, 19____, to <b>1/8</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>1/7</b> , 19 <b>49</b> , and that death occurred at <b>6:30</b> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Benjamin M.D.</b>				23b. ADDRESS <b>7430 Virginia</b>		23c. DATE SIGNED <b>1/8/49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JAN. 11 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>S. S. PETER &amp; PAUL CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>				
DATE REC'D BY LOCAL REG. <b>JAN 10 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lacater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thomas Kutis 2906 Harris</b>					

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

7430 Virginia  
Dr. Benjamin Beers and

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 .....  
Student Embalmer

Signed Leo J. Budd  
Licensed Embalmer No. 3989  
P. O. Address St. Louis, Mo

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.