

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **17269**  
**4131**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
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</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>4615 Pope Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4615 Pope Ave.</b>				d. STREET ADDRESS (If rural, give location) <b>4615 Pope Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Margaret Gander</b>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>May 8, 1949</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>July 3, 1866</b>		9. AGE (In years last birthday) <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Martin Lorenz</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Hoffman</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Mollie Mignerone, 3523 Osage St.</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.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio-sclerosis</b>				many years			
DUE TO (c) _____				_____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				_____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>St. Louis</b>		_____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>may 7 1949</b>			
22. I hereby certify that I attended the deceased from <b>1-15</b> , 1949, to <b>May 7</b> , 1949, that I last saw the deceased alive on <b>May 7, 1949</b> , and that death occurred at <b>12:30</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Albert Kaplan M.D.</b>				23b. ADDRESS <b>607 N. Grand</b>		23c. DATE SIGNED <b>5-9-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 10, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 9 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Houston</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>William Schumacher, 3013 Meramec</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

Lx 1000  
Dr. A Kaplan  
University Club Bldg

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Francis Williamson*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *3565*

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.