U.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36398

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9417

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5426 ROBERT

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS 2029
d. STREET ADDRESS (If rural, give location) 5426 ROBERT

3. NAME OF DECEASED (Type or Print) a. (First) MATHILDA b. (Middle) c. (Last) GASS

4. DATE OF DEATH (Month) (Day) (Year) OCT. 10 1952

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH DEC. 23 1880
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) MISSOURI
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME PHILIP MOESER
13b. MOTHER'S MAIDEN NAME MATHILDA BABRICK
14. NAME OF HUSBAND ~~OR WIFE~~ JACOB GASS

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. NONE
17. INFORMANT'S SIGNATURE OR NAME ADDRESS JACOB GASS 5426 ROBERT

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Colitis — 3 Months
DUE TO (c) Cause unknown

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 5723

22. *I hereby certify that I attended the deceased from* 3 Oct, 1952, *to* 10 Oct, 1952, *that I last saw the deceased alive on* 10 Oct, 1952, *and that death occurred at* 2:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Roy H Schmiemeier MD
23b. ADDRESS 6817 Gravois
23c. DATE SIGNED 10/11/52

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
24b. DATE OCT. 13 1952
24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.
24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo

DATE REC'D BY LOCAL REG. OCT 14 1952
REGISTRAR'S SIGNATURE J Earl Smith MD MJB.
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis 2906 ADDRESS Gravois

(Licensed Embalmer's Statement on Reverse Side)

6817 a/ Francis
2 to 4 P.M.

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. Budde

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.