

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40231

State File No. _____
Registrar's No. 9961

FILED DEC 2 1952

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (in this place)		2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 5325 West	

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle)	c. (Last) Gieselman	4. DATE OF DEATH (Month) (Day) (Year) Oct 28, 1952
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5. SEX male <input checked="" type="radio"/>	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH July 8, 1881	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 1 DAY Days	IF UNDER 1 MIN. Hours	IF UNDER 1 SEC. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Theophile Gieselman	13b. MOTHER'S MAIDEN NAME Charlotte Wurtz	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lillian Inman	ADDRESS 5325 West
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arterio sclerotic Heart Disease</i> DUE TO (c) <i>Disease</i>		
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:08 p.m., from the causes and on the date stated above.

23a. SIGNATURE Patrick C. Taylor Cov. (Disease or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10-29-52
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 10/30/52	24c. NAME OF CEMETERY OR CREMATORY St Paul Churchyard	24d. LOCATION (City, town, or county) (State) St Louis County Mo.
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DATE REC'D BY LOCAL REG. OCT 29 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L. Ziegenhein & Sons 7027 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

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

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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.

Student
Student Embalmer

Signed B. Q. Kedwell

Licensed Embalmer No. 3877

P. O. Address 7027 Grand

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.