No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19432

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4625

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,
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) 4231 W. LEXINGTON AVE 2109

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,
d. STREET ADDRESS (If rural, give location) 4231 W. LEXINGTON AVE

3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) J. c. (Last) GOTTWALD 0
4. DATE OF DEATH (Month) (Day) (Year) MAY 5, 1953

5. SEX MALE 0
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH 6/17/1879
9. AGE (In years last birthday) 73 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) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME LOUIS GOTTWALD
13b. MOTHER'S MAIDEN NAME ELIZABETH STEWART
14. NAME OF HUSBAND OR WIFE KATHERINE GOTTWALD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. #
17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS BERNICE KOCH 4231 W LEXINGTON AVE

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) Ventricular failure — INTERVAL BETWEEN ONSET AND DEATH 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis — 4 years

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? 4222

22. I hereby certify that I attended the deceased from June 10th, 1944, to May 6, 1953, that I last saw the deceased alive on 5-2-53, 19__, and that death occurred at 2:45 a m., from the causes and on the date stated above.

23a. SIGNATURE Russell Glaser 2 (Degree or title) D.O.
23b. ADDRESS 4032a W Flaussant
23c. DATE SIGNED 6/5/53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 5/7/53
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI

DATE REC'D BY LOCAL REG. MAY 6 1953
REGISTRAR'S SIGNATURE J Carl Smith MD MJB
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE

(Licensed Embalmer's Statement on Reverse Side)

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 Albert Maffield

Licensed Embalmer No. 3077

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.