

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. **9770**

No. 300
10-48

FILED OCT 23 1953

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital		e. STREET ADDRESS (If rural, give location) 4260 Delor Street	
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Gaspar c. (Last) (Gaspar)			4. DATE OF DEATH (Month) (Day) (Year) Oct 11 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 2 1889
9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher	10b. KIND OF BUSINESS OR INDUSTRY Maat	11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? U S
13a. FATHER'S NAME John Gaspar	13b. MOTHER'S MAIDEN NAME Julis Predy	14. NAME OF HUSBAND OR WIFE Julia (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes Gaspar 4260 Delor Street	
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) Crown haemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Pulmonary emphysema & fibrosis 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.	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5271	
22. I hereby certify that I attended the deceased from 1-22 , 19 52 , to 10-10 , 19 53 , that I last saw the deceased alive on 10-10 , 19 53 , and that death occurred at 1 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) William A. Kern MD		23b. ADDRESS 16 Hampton Village Plaza	23c. DATE SIGNED 10-12-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/14/53	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo.
DATE REC'D BY LOCAL REG. OCT 13 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mejdell Funeral Home 1926 Allen Av	

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.....
Signature of Student Embalmer

Signed *R. Reinhold K. Lehman*.....

Licensed Embalmer No. *332*.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.