

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26120

State File No.

FILED AUG 1 - 1957

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 6495

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6495			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution residence before attribution). a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN 4000 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 (If not in hospital or institution, give street address or location) 31 St. Louis State Hospital				e. STREET ADDRESS (If rural, give location) 27 7510 Forest View, Normandy, Mo.					
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Gantner			4. DATE OF DEATH (Month) (Day) (Year) July 10, 1957						
5. SEX / Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Sept. 29, 1879			
9. AGE (In years last birthday) 77		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) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (City and State or Foreign Country) Moline, Kansas			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME James Martin		13b. MOTHER'S MAIDEN NAME Abeliva Baker		14. NAME OF HUSBAND OR WIFE Victor Gantner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. Vistor Gantner			ADDRESS 7510 Forest View	
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) Peritonitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cholecystectomy for chronic cholecystitis DUE TO (c) 585X II. OTHER SIGNIFICANT CONDITIONS Chronic brain syndrome associated with HCVD with psychotic reaction, Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 10 days		
19a. DATE OF OPERATION		19b. NATURE AND CAUSE OF OPERATION Cholecystectomy with cardiac decompensation					20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 2-1, 1954, to 7-10, 1957, that I last saw the deceased alive on 7-10, 1957, and that death occurred at 9:45p.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Cecilia Arman				23b. ADDRESS 5400 Arsenal Sr.		23c. DATE SIGNED 7-11-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE July 13 1957		24c. NAME OF CEMETERY OR CREMATORY WALNUT HILL CCM		24d. LOCATION (City, town, or county) (State) BELLEVILLE ILL.			
DATE REC'D BY LOCAL REG. JUL 12 57		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutes 2906 Lewis					

(Licensed Embalmer's Statement on Reverse Side)

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

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 Leo J. Burke
Licensed Embalmer No. 398
P. O. Address H. Row

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.