

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011661
STATE FILE NUMBER
2867

FILED MAR 19 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION No. Baptist Hospital (54 Yrs)		Length of stay in 1b 15 1/2	d. STREET ADDRESS (If outside, give location) 6150 Kingsbury
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Minnie Grothe Gist			4. DATE OF DEATH Month Day Year March 10, 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1874	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Chillicothe, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Grothe	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Thomas Burns Gist
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Miss Gertrude Dell 6150 Kingsbury	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Myocarditis Arteriosclerosis. Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2-20-58 3-10-58 3-22-58
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis	
	DUE TO (c) Cerebral hemorrhage	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 422.1
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 4-20-57	20f. CITY, TOWN, OR LOCATION 3-10-58	COUNTY	STATE
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21. I attended the deceased from Death occurred at 7:25	April 20, 1957 to March 10, 1958	and last saw her alive on March 10, 1958
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22a. SIGNATURE Maurice A. Diehl (Degree or title) M.D.	22b. ADDRESS 8924 St. Charles Rd.	22c. DATE SIGNED 3/11/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/13/58	23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
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24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd	25. DATE RECD. BY LOCAL REG. MAR 11 '58	26. REGISTRAR'S SIGNATURE Charles Smith MD
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr.M.A.Diehr
8924a St.Charles Rock Rd.
Ha.8 - 8100
11 A.M. To 2 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
Signature of Student Embalmer _____

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *2440*

P. O. Address *6175*

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.