

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026971
STATE FILE NUMBER

XC-5832372 SL 340

818

1003

Registrar's No. 6620

S. 300
1-57

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO		c. CITY OR TOWN LEMAY 4870	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside give location) 117 E. VERMA	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK C. GAUER		4. DATE OF DEATH Month Day Year 6/ 30/ 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-24
9. AGE (In years last birthday) 33		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME FRANK L. GAUER		13b. MOTHER'S MAIDEN NAME LILLIAN LUECKE	14. NAME OF HUSBAND OR WIFE MARION E. GAUER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 495228287	17. INFORMANT Address VAH RECORDS 915 N. GRAND AVE., ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO (b) ASTROCYTOMA OF THE RIGHT CEREBRAL HEMISPHERE DUE TO (c) - - - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - - - 1930			INTERVAL BETWEEN ONSET AND DEATH 6 YEARS
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 5:10 PM		and last saw him alive on 6/30/58	
22a. SIGNATURE FELIX G. JABCZANSKI		22b. ADDRESS M.D. VAH 915 N. GRAND, ST. LOUIS, MO.	
22c. DATE SIGNED 7/1/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 3, 1958	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.	
24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 781 1/2 S. Broadway		25. DATE RECD. BY LOCAL REG. JUL 2 1958	
		26. REGISTRAR'S SIGNATURE Charles Smith Mo mfb.	

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 *Eric C. Branson*

Licensed Embalmer No. *4764*

P. O. Address *St. Louis*

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.