

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035082

FILED SEP 29 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2389

300  
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CONCORD VILLAGE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>CONCORD VILLAGE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt 14-Box 520</u>			Length of stay in 1b <u>38 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>Rt 14-Box 520</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LYDIA.</u> Middle <u>H.</u> Last <u>GAEBLER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>12</u> Year <u>1958</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT-23-1886</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>E. ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>HENRY MANNLE</u>				14. MOTHER'S MAIDEN NAME <u>MARY PAHLICH</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DOROTHY STOLLE</u> Address <u>Rt 14-Box 522 BEETON MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Debilities of age, senility</u>						
		DUE TO (c) <u>593X</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <u>Arteriosclerotic Cardiovascular disease, Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.)					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>								
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 <u>June 5, 1957</u> to <u>Sept 12, 1958</u> and last saw her alive on <u>Sept 12, 1958</u> Death occurred at <u>5:40 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Leo P. Wacker MD</u>				22b. ADDRESS <u>9 Concord Center Drive, St Louis 23</u>		22c. DATE SIGNED <u>9/15/58</u>		
23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST JOHNS PER.</u>		23d. LOCATION (City, town, or county) <u>MEHLVILLE MO</u>		23e. (State)		
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE MO.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-15-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke m. D.</u>		

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 *Clarence M. Bilt*

Licensed Embalmer No. *43*  
P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.