

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045736
STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12327

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 Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN IMPERIAL	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FAITH HOSPITAL		d. STREET ADDRESS (If outside, give location) 29 ROUTE # 2	
3. NAME OF DECEASED (Type or print) First Middle Last Louis F GUST		4. DATE OF DEATH Month Day Year DEC 18 1958	
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 JUNE 11 1887
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STOCK CLERK	
11. BIRTHPLACE (City and state or country) BOHEMIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME FRANK GUST		13b. MOTHER'S MAIDEN NAME LOUISE PISKOVA	
14. NAME OF HUSBAND OR WIFE BARBARA GUST		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. 489-22-2251		17. INFORMANT BARBARA GUST ROUTE 2 BOX 346	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LINITIS PLASTICA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Rheumatic H. Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs +
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 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Oct. 1947 to Dec 18 1958 and last saw her alive on December 18 58 Death occurred at 12:02 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles Secor, M.D.		22b. ADDRESS 9279 Prataan Dr	
22c. DATE SIGNED 12/20/58		22d. STATE MO	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE DEC 22 1958	
23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) (State) ST. Louis MO	
24. FEDERAL DIRECTOR Thomas Kutis 2906 Gravia		25. DATE RECD. BY LOCAL REG. DEC 22 58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. M. J. B.			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

11-1-25
2-5-84

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 Harvey Kelle

Licensed Embalmer No. 4596

P. O. Address Flouissant, M

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.