

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045738

STATE FILE NUMBER

FILED DEC 22 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's

11878

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 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5975a Wells Ave		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5975a Wells Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Michael J Gyrog			4. DATE OF DEATH Month Day Year 12-8-58		
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 10-23-1905		9. AGE (In years last birthday) 53

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer	10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Michael Gyrog	13b. MOTHER'S MAIDEN NAME Theresa Hiedenger	14. NAME OF HUSBAND OR WIFE Edna Gyrog
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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. Unk	17. INFORMANT Edna Gyrog 5975a Wells Ave.
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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) <i>Cardio Vascular Degenerative Disease with coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>
DUE TO (b) <i>Coronary occlusion</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.1</i>		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.)	
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 <i>26 April 58</i> to <i>8 Dec 58</i> and last saw him alive on <i>1 Dec 58</i> Death occurred <i>8 Dec 58 8:00 a.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <i>Luke A. Fulse MD</i>	(Degree or title)	22b. ADDRESS <i>1506 Hodiamont av</i>	22c. DATE SIGNED <i>8 Dec 58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-11-58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
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24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiamont Ave.	ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 10 58	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> mrb
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(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Case 15800

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 *Alfred J. Doedecker* .....

Licensed Embalmer No. *2663*  
P. O. Address *11257 Hudson*

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.