

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003251

STATE FILE NUMBER

JAN 28 1959

Registration District No.

Primary Registration District No.

Registrar's No.

2409

300  
-57

16  
1959

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms with diseases. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP</b>		Length of stay in lb <b>#1 3 Days</b>	d. STREET (If outside, give location) ADDRESS <b>3125 Nebraska Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>F.</b> Last <b>MACK</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>11,</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1888</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months <b>1</b> Days <b>2</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>
10a. BIRTHPLACE (City and state or country) <b>St. Louis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Henry Mack</b>		13b. MOTHER'S MAIDEN NAME <b>Christina Kaiser</b>	14. NAME OF HUSBAND OR WIFE <b>Lillian Kramer Mack</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>494-28-3409</b>	17. INFORMANT <b>Lillian Mack</b> Address <b>3125 Nebranka Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>Atherosclerotic Heart Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420-0</b>			INTERVAL BETWEEN ONSET AND DEATH
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.) <b>420-0</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <b>1/8/59</b> to <b>1/11/59</b> and last saw <sup>her</sup> him alive on <b>1/11/59</b> Death occurred at <b>8:50 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Donald W. Gebken, M.D.</i>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>1/11/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/14/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Gebken Sons</b> ADDRESS <b>2630 Gravois Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 13'59</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> S.P.

**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 *Herbert J. Gandy* .....

Licensed Embalmer No. 4800 .....  
P. O. Address Kirkwood, Mo. .....

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.