Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003709
STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 25

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Brentwood Mo. Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hospt. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY ST. LOUIS
c. CITY OR TOWN Wellston 4301 Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6435 Chatham Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Mary Middle Last Gardella

4. DATE OF DEATH Month 1 Day 2 Year 1959

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 24, 1894
9. AGE (In years last birthday) 64 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) St. Louis
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Dillon
13b. MOTHER'S MAIDEN NAME Ellen (unk)
14. NAME OF HUSBAND OR WIFE Frank Gardella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unk.
17. INFORMANT Frank Jones Address 2413 N. 9th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) INFARCTION.
DUE TO (c) ARTERIOLAR SCLEROTIC HEART DISEASE
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
TUMOR OF LEFT KIDNEY. (ADENOMA) 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-27-58, to 1-2-59 and last saw her/him alive on 1-2-59
Death occurred at 9:57 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE D. B. Holley (Degree or title) M.D.
22b. ADDRESS 601 S. Brentwood
22c. DATE SIGNED 1/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify) 1/5/59
23b. DATE Removal
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis (State) Mo

24. FUNERAL DIRECTOR Robert D. Kinealy ADDRESS 2228 St. Louis Ave
25. DATE RECD. BY LOCAL REG. 1-3-59
26. REGISTRAR'S SIGNATURE Herbert R. Hanke, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Kahle

Licensed Embalmer No. 4596

P. O. Address Vermont

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.