

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007127

STATE FILE NUMBER

2-1135

FILED FEB 17 1959

Registration District No.

Primary Registration District No.

Registrar No.

300  
-57

14

92  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 932 N.8th St.	
3. NAME OF DECEASED (Type or print) First Agostina		Middle Vittoria		Last Gastro-Castro	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 19, 1881		9. AGE (In years last birthday) 77		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days 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 At Home		11. BIRTHPLACE (City and state or country) Italy 5	
12. CITIZEN OF WHAT COUNTRY? Italy		13a. FATHER'S NAME Peitro Vittoria		13b. MOTHER'S MAIDEN NAME Santa (UNKNOWN)	
14. NAME OF HUSBAND OR WIFE Late Marino Gastro		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gus Gastro		Address 3249 Nebraska			
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>Left ventricular failure</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>chronic hypertensive nephropathy</i>					<i>6 mo</i>
DUE TO (c) <i>chronic interstitial nephritis</i>					<i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Complete left sided hemiplegia.</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>592+</i>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Oct 2-58</i> to <i>Jan 30-59</i> and last saw her <i>live on Jan 30-59</i> Death occurred at <i>5:40 p.m.</i> on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE <i>G. H. Snyder M.D.</i>		(Degree or title)		22b. ADDRESS <i>705 Olive St.</i>	
22c. DATE SIGNED <i>1-31-59</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/3/59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	
23d. LOCATION (City, town, or county) <i>St. Louis, Mo.</i>		(State)			
24. FUNERAL DIRECTOR <i>Kriegshauser 4228 S. Kingshighway</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 2 '59</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *William P. White* .....

Licensed Embalmer No. *4241* .....

P. O. Address *528 So. Kingsley* .....

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.