

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010935
STATE FILE NUMBER
2-2619

FILED MAR 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57

1
594
0

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS 5415 Grace Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last EMIL H. GAST			4. DATE OF DEATH Month Day Year Mar. 13 1959
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 Dec. 15, 1888
9. AGE (In years last birthday) 70		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) Baker (Retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis County, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Gast	
13b. MOTHER'S MAIDEN NAME Emma Knittle		14. NAME OF HUSBAND OR WIFE Emma Gast	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give exact date of service) No None		16. SOCIAL SECURITY NO. 492-05-2252	17. INFORMANT Address Emma Gast 5415 Grace Ave.
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 Embolism			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Rheumatic Heart disease VHD			
DUE TO (c) Mitral stenosis 410X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 Jan 26-1959 to March 13-1959 and last saw him alive on March 13-1959 Death occurred at 5:50 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward W. Liffman M.D.		22b. ADDRESS 3606 Linn	
		22c. DATE SIGNED 3-14-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 16, 1959	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. 3-14-59	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

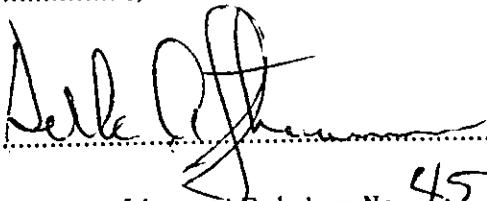
MEDICAL CERTIFICATION

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 
Licensed Embalmer No. 4533
P. O. Address

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.