

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015013

STATE FILE NUMBER
Registrar's 4095

FILED MAY 11 1959

Registration District No. Primary Registration District No.

300
-57
7
793
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) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 6100 Garesche	
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Gilsdorf		4. DATE OF DEATH Month Day Year April 24, 1959	
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 Nov. 9, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Hungary
13a. FATHER'S NAME Henry Aubermann		13b. MOTHER'S MAIDEN NAME Caroline Lukas	14. NAME OF HUSBAND OR WIFE Ludwig Gilsdorf
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. none	17. INFORMANT Address Caroline Kistner 6100 Garesche
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>acute Posterior Infarction</i> Conditions, if any, which gave rise to above cause (b) <i>Anteriosclerotic Heart Disease</i> Underlying cause (c) <i>Generalized Anteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>stat.</i> <i>24 hrs.</i> <i>24 hrs.</i>
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 WORK <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 April 23, 1959 to April 24, 1959 and last saw her alive on April 24, 1959 Death occurred at 11:50 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>4/24/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>4/28/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Buchholz Mortuary 5967 W. Florissant</i>		25. DATE RECD. BY LOCAL REG. <i>APR 27 '59</i>	26. REGISTRAR'S SIGNATURE <i>W. Earl 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 *Walter J. Bush*

Licensed Embalmer No. 4551

P. O. Address *W. J. Bush*

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.