

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027511

FILED VS AUG 3 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1992 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis County</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>YRS</b>	c. CITY OR TOWN <b>Kirkwood</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>101 East Essex</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>101 East Essex</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Eugene C. Gummersbach</b>	First Middle Last	4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1959</b>
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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>7-28-84</b>	9. AGE (last birthday) <b>74</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESIDENT</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>B. HERDER BOOK CO</b>	11. BIRTHPLACE (City and state or country) <b>ST LOUIS MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JOSEPH H GUMMERSBACH</b>	13b. MOTHER'S MAIDEN NAME <b>ELIZABETH BULTE</b>	14. NAME OF HUSBAND OR WIFE <b>HELEN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>488-10-7537</b>	17. INFORMANT <b>HELEN GUMMERSBACH-KIRKWOOD</b>	Address <b>101 E. ESSEX</b>
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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>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Wkks</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>Bronchogenic Carcinoma</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	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, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>January 15 59</b> to <b>July 25 59</b> and last saw him alive on <b>7-19-59</b> . Death occurred at <b>Appt. to Dr. [unclear]</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Dr. A. Munsch</b>	22b. ADDRESS <b>35 N Central Christian</b>	22c. DATE SIGNED <b>7-25-59</b>
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23a. BURIAL CREATION/REMOVAL DATE <b>7-28-59</b>	23b. DATE <b>7-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO</b>
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24. FUNERAL DIRECTOR <b>Arthur J. [unclear]</b>	ADDRESS <b>3840 Lindbergh Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>7-25-59</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James Williams

Licensed Embalmer No. 356

P. O. Address 3840 X

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.