

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041859

STATE FILE NUMBER

FILED VS. DEC 7 1959

210935

UNRECORDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>over 2 yrs.</b>	c. CITY OR TOWN <b>St. Louis, Mo.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4516 Westminster Pl.</b>
3. NAME OF DECEASED (Type or print) First <b>VIOLET</b> Middle <b>B.</b> Last <b>GASSLANDER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</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>5-17-99</b>
9. AGE (last birthday) <b>60 yrs</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>formerly: teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Colleges</b>	11. BIRTHPLACE (City and state or country) <b>Lorraine, Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>George Walter</b>	
13b. MOTHER'S MAIDEN NAME <b>Florence Kiest</b>		14. NAME OF HUSBAND OR WIFE <b>Karl Gasslander</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Karl Gasslander, 4516 Westminster</b>
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>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>420.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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) <b>Arteriosclerotic Brain Disease</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 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	
21. I attended the deceased from <b>July 22, 1957</b> to <b>Nov. 24, 1959</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Nov. 24, 1959</b> Death occurred at <b>10:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>L. Hopstatter, M.D.</b> (Degree or title)		22b. ADDRESS <b>5400 Arsenal St.</b>	22c. DATE SIGNED <b>11-24-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>11-25-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 25 1959</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

