

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN - 4 1960 317

'59 0 46383
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3448

UNDECEASED

1. PLACE OF DEATH a. COUNTY ST Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy, Mo.		c. CITY OR TOWN Normandy	
Length of stay in 1b MONS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mother Good Council Home		d. STREET ADDRESS (If outside, give location) 6825 Natural Bridge	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Monsuri M. Gustine			4. DATE OF DEATH Month Day Year Dec. 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 unk About 91	9. AGE (last birthday) About 91	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) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Syria	12. CITIZEN OF WHAT COUNTRY USA
------------------------------------------------------------------------------------------------------------	--------------------------------------------------	------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Unk. Wolff	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Joseph Gustine
-----------------------------------------	------------------------------------------	------------------------------------------------------

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. no	17. INFORMANT Address Mrs. Marie Coyle 7138 Forsyth
-----------------------------------------------------------------------------------------------------------------------	--------------------------------------	---------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) none
---------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour Month, Day, Year p.m. none	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from 1948 to Dec 24, 59 and last saw her him alive on Dec. 23, 59 . Death occurred at 11 am. on the date stated above, and to the best of my knowledge, from the causes stated.	
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. SIGNATURE (Degree or title) M. Staehle MD	22b. ADDRESS 7124 Natural Bridge	22c. DATE SIGNED 12-25-59
----------------------------------------------------------	--------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-26-59	23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
------------------------------------------------------------	------------------------------	------------------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. 12-25-59	26. REGISTRAR'S SIGNATURE J. C. Murphy M.D.
------------------------------------------------------------------------------------------------	-------------------------------------------------	-------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Staehle
7325 Ravenna
or
de Paul Hosp

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 _____

Licensed Embalmer No. 424

P. O. Address St. Louis

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.