

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020943

FILED VS JUN 9 1960

318

Primary Registration District No. 1003

Registrar's No. 5580

STATE FILE NUMBER

| | | | | | | | | | | | | | |
|--|--|----------------------------------|---|---|---|--|--|--|--|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1 | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5258 Fairview | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) Evelyn Gardner | | | | 4. DATE OF DEATH Month 5 Day 28 Year 60 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 9-1-1890 | | 9. AGE (last birthday) 69 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 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) St. Louis, Mo. | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | |
| 13a. FATHER'S NAME August Gardner | | | | 13b. MOTHER'S MAIDEN NAME Mayme Hackett | | | | 14. NAME OF HUSBAND OR WIFE divorced | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Mr. Harold J. Cuddy 5258 Fairview | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.] DUE TO (b) Arteriosclerosis, generalized DUE TO (c) 331x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 4-16-60 to 5-28-60 and last saw her alive on 5-28-60 Death occurred at 2:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE Robert W. Muellerhoff M.D. (Degree or title) | | | | | | 22b. ADDRESS 1515 Lafayette Ave. | | | 22c. DATE SIGNED 5-28-60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 5-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | | | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark 1125 Hodiamont Ave. | | | | 25. DATE RECD. BY LOCAL REG. MAY 31 1960 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | | | | | | |

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

Harvey Frahl

Licensed Embalmer No. 4590

P.O. Address: St. Louis

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.