

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 27 1960

-60-048233

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3601

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u> Length of stay in 1b _____ c. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. -If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____ c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>5406^o LOUGHBOROUGH</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED First Middle Last <u>FRANCES E GUBSER</u>			4. DATE OF DEATH Month Day Year <u>DEC 12 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 2 1891</u>	9. AGE (last birthday) <u>69</u>	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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO. USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>AMBROSE ZURFLUH</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH NUNN</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM GUBSER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>WILLIAM GUBSER 5406^o LOUGHBOROUGH</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus of thrombotic</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cerebral vascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>nodular goiter</u>		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 checked="" 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 a.m. p.m. Month, Day, Year					
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE

21. I attended the deceased from 11-26-60 to 12-11-60 and last saw her/him alive on 12-10-60
 Death occurred at 5:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John H. Tuttle MD</u>		22b. ADDRESS <u>950 Francis Pl Clayton Mo</u>		22c. DATE SIGNED <u>12-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>DEC 14 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
24. GENERAL DIRECTOR <u>Thomas H. Tuttle 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>12-13-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James C. Allen

Licensed Embalmer No. 434

P. O. Address 2906 *

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