

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019000
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4605

FILED MAY 19 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		c. CITY OR TOWN <u>St Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Anthony's Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>3179 Hampton</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE GARDINE</u>			4. DATE OF DEATH Month Day Year <u>May 15 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1896</u>
9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchboard operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Congress Hotel</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>			
13a. FATHER'S NAME <u>Joseph Schwetz</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Krs</u>	14. NAME OF HUSBAND OR WIFE <u>John Gardine (Dec'd)</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.	17. INFORMANT Address <u>Cecilia Schwetz 3179 Hampton</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>ACUTE POSTERO-LATERAL-APICAL MYOCARDIAL INFARCTION & CONGESTIVE FAILURE + Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4201</u>			
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 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 a.m. 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
21. I attended the deceased from <u>1956</u> to <u>5/15/61</u> and last saw him alive on <u>5/14/61</u> Death occurred at <u>4:20 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles B. [Signature]</u>		22b. ADDRESS <u>7430 VIRGINIA AVE ST (11)</u>	22c. DATE SIGNED <u>5/15/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-18-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Co Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 16 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>

130-4 Monday

V 103-134

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jarrow

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.