

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025519

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1968

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4031

2 4008

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4 1

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9 260X

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12 86-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

FILED JUL 9 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST. LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		a. STATE <u>Mo</u> b. COUNTY <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chas I Nursing Home</u>		Length of stay in 1b <u>WKS</u>		c. CITY OR TOWN <u>Jennings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>1825 Mora Lane</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. (If outside, give location) RESIDE ON FARM Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Krause</u> Last <u>Krause</u>			4. DATE OF DEATH Month <u>7-</u> Day <u>3-</u> Year <u>1962</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>10-18-95</u>		9. AGE (last birthday) <u>86</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>AT Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Harrison Ohio</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Gantzwart</u>		13b. MOTHER'S MAIDEN NAME <u>Edw C</u>	
14. NAME OF HUSBAND OR WIFE <u>Edw C</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>None</u>	
17. INFORMANT <u>Henry J. Rut</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Bacteremia</u>		DUE TO (b) <u>Decubitus Ulcers</u>		<u>12 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Diabetic Neuropathy</u>				<u>2 years</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 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 <u>Jan 1-1962</u> to <u>Death</u> and last saw her <u>7/2/62</u> alive on <u>7/2/62</u>		Death occurred at <u>7 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John M. McCarthy MD</u>		22b. ADDRESS <u>4161 Luedell-St Louis</u>		22c. DATE SIGNED <u>7/4/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>7-5-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>	
23d. LOCATION (City, town, or county) <u>ST. LOUIS CO</u>		(State) <u>Mo</u>		24. FUNERAL DIRECTOR <u>O'Sullivan Muckle Hon Jennings Rd</u>	
25. DATE RECD. BY LOCAL REG. <u>7-4-62</u>		26. REGISTRAR'S SIGNATURE <u>John M. Murphy MD</u>			

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,

~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Lawrence O. Gerling

Licensed Embalmer No. 4979

P. O. Address Berkeley, Mo.

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.