

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

163-049470
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12612

FILED DEC 27 1963

DO NOT WRITE ON THIS STUB

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	STATE AMENDED	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>217</u>				
3				
4 <u>0</u>				
5 <u>0</u>				
6				
7 <u>0</u>				
8 <u>2</u>				
9				
10				
11				
12 <u>86-0</u>				
13				
<u>86</u>	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 checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>PARKSIDE MANOR N.H.</u>		d. STREET ADDRESS (If outside, give location) <u>1919 S. GRAND</u>	
Inside Limits Yes <input checked="" 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>PETER E. GULATH</u>			4. DATE OF DEATH Month Day Year <u>12/19/63</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/93</u>
9. AGE (last birthday) <u>70 YRS</u>		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) <u>STOREKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PULLMAN R.R.</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>CHARLES GULATH</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA NEUDECKER</u>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W. I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARIE KOUBEK</u>		Address <u>1327 DALLWOOD DR. 26</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>Carcinoma of Prostate with metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			<u>177X</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 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>Dec. 1, 1963</u> to <u>Dec. 19, 1963</u> and last saw him alive on <u>Dec. 19, 1963</u> Death occurred at <u>11:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Jason Birenbaum, M.D.</u>		22b. ADDRESS <u>7171 Delmar, St. Louis, Mo.</u>	
22c. DATE SIGNED <u>12/20/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12/23/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>E. J. SCHNUR 3125 LAFAYETTE AVE.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 20 1963</u>	REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

X

ST. LOUIS, MO. ST. LOUIS, MO.
JANUARY 1, 1900 JANUARY 1, 1900

NAME OF DECEASED SEX AGE OCCUPATION PLACE OF BIRTH DATE OF BIRTH GRAVE REGISTERED YES NO

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 Robert M. Murray
Licensed Embalmer No. 2749

P. O. Address St. Louis, 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.