

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

DEF-FILED 15 64

PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION Incarnate Word HospitalInside Limits
Yes ☐ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTYc. CITY
OR
TOWN St. LouisInside Limits
Yes ☐ No ☐d. STREET
ADDRESS (If outside, give location)
5528 Botanical Ave.Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)First
ELIA

Middle

Last
GUELKER4. DATE
OF
DEATHMonth
Sep.Day
30Year
1964

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

6-16-1895

9. AGE (last birthday)

69

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)
Housework10b. KIND OF BUSINESS OR INDUSTRY
At Home11. BIRTHPLACE (City and state or country)
St. Louis, Mo.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Thomas O'Connell

13b. MOTHER'S MAIDEN NAME

Mary Kick

14. NAME OF HUSBAND OR WIFE

Aloysius L. Guelker

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.

17. INFORMANT

Address

Aloysius L. Guelker 5528 Botanical Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO (b)

DUE TO (c)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Ruptured Aortic
Aneurysm
451XINTERVAL BETWEEN
ONSET AND DEATHPART 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.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐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 9-10-64 to 9-30-64 and last saw her alive on 9-30-64
Death occurred at 10:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE

Oct. 3, 1964

23c. NAME OF CEMETERY OR CREMATORY

S/S Peter & Paul Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Kriegshauser 4228 S. Kingshighway Blvd.

25. DATE RECD. BY LOCAL REG.

OCT 1 1964

26. REGISTRAR'S SIGNATURE

Road Smith, M.D.

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 William B White

Licensed Embalmer No. 4291

P. O. Address _____

* 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.