

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH 4448

5875

FILED FEB 26 1957

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>4448</u> - PRIMARY REG. DIST. NO. <u>6024</u>		Registrar's No. <u>23</u>	
1. PLACE OF DEATH a. COUNTY <u>Ray</u> b. CITY (If outside corporate limits, write RURAL and give town) <u>Lawson</u> c. LENGTH OF STAY (in this place township) <u>49 yrs</u> d. FULL NAME OF HOSPITAL OR INSTITUTION _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> c. CITY OR TOWN <u>Lawson</u> <u>0890</u> d. Is Resident within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> STREET ADDRESS (If rural, give location) _____		
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) <u>GEORGE</u> c. (Last) <u>GSTREIN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 16 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov 22 1883</u>	9. AGE (to years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Fort Worth Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Jacob Gstrein</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lafelt</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Gstrein Lawson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-40-6746</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Kathryn Rogers Lathrop Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis &amp; Auricular Fibrillation</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 yrs.</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lawson Ray Mo.</u>	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>1946</u> , to <u>Feb 16</u> , 1957, that I last saw the deceased alive on <u>Feb 16</u> , 1957, and that death occurred at <u>2:50 P. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Detlev Buehner MD.</u>		23b. ADDRESS <u>Lawson Mo.</u>		23c. DATE SIGNED <u>2/18/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 18, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>		
DATE REC'D BY LOCAL REG. <u>Feb 23 - 1957</u>	REGISTRAR'S SIGNATURE <u>Malcolm</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jerman-Prichard Lawson Mo</u> (Licensed Embalmer's Statement on Reverse Side)			

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

MAR 12 1957

86 9th

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.....  
*Lindell Jarman*

Licensed Embalmer No. *4589*  
*Cerebus Springs, Pa.*  
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.