

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38991

File No. _____
Registered No. **11468**
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **7.11**
Township..... Primary Registration District No. **20034**
City..... (No. **Sarah Olive St**)

2. FULL NAME

John A Gerster
(a) Residence. No. **7518² Forsyth Ave** St. **19** Ward. **St Louis 08, Mo**
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF **Vernie Gerster**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 11 1866**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 3 11

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Salesman Automobile**
(b) General nature of industry, business, or establishment in which employed (or employer) **Parts**
(c) Name of employer **Franklin Motor Co**

172

2

PARENTS

31

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **M. of**

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT **Vernie Gerster**
(Address) **7518² Forsyth**

15. FILED **NOV 23 1929** **Max C. Hanker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 22 1929**

17. I HEREBY CERTIFY, That I attended deceased from **7th August** 1929, to **Nov 22** 1929, that I last saw him alive on **Nov 20** 1929, and that death occurred, on the date stated above, at **1:00 pm**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
94A angina pectoris
93C
94B

(duration) yrs. mos. ds.
CONTRIBUTORY **Myocarditis - Cardiac asthma** (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **physical diagnosis**
(Signed) **S. A. Peate**, M. D.

, 19 (Address) **705 N Kings Highway**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Elkhart Ind Mo. 25** DATE OF BURIAL **1929**

20. UNDERTAKER **Philander Craig Washington** ADDRESS **11468**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RESERVED FOR BINDING

