

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

Do not use this space.

6198

1. PLACE OF DEATH

County St Louis Registration District No. 784 File No. _____
 Township St Ferdinand Primary Registration District No. 6030 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Kate Henrietta Gerbes

(a) Residence No. Sanbells Ferry & Roberson Mill Pond Ward _____ (If nonresident, give city or town and State)
 (Usual place of abode)

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 Female 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

Bernard A Gerbes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 28 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 10 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Flourissant mo

10. NAME OF FATHER Fred Benne

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

12. MAIDEN NAME OF MOTHER Anna Nachoniska

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

14. INFORMANT Bernard A Gerbes

(Address) Cross Keys mo

15. FILED Feb 10 1930 O. H. Schrade M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1930 to Feb 2 1930 that I last saw her alive on Feb 2 1930, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A

CONTRIBUTOR (SECONDARY) 7401 (duration) yrs. mos. ds. 4 1/2 hrs

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? _____

(Signed) J. J. Millmann, M. D.

Feb 2 1930 (Address) Flourissant - Mo

*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 Sacred Heart Cemetery DATE OF BURIAL 2/6 1930
Flourissant Mo

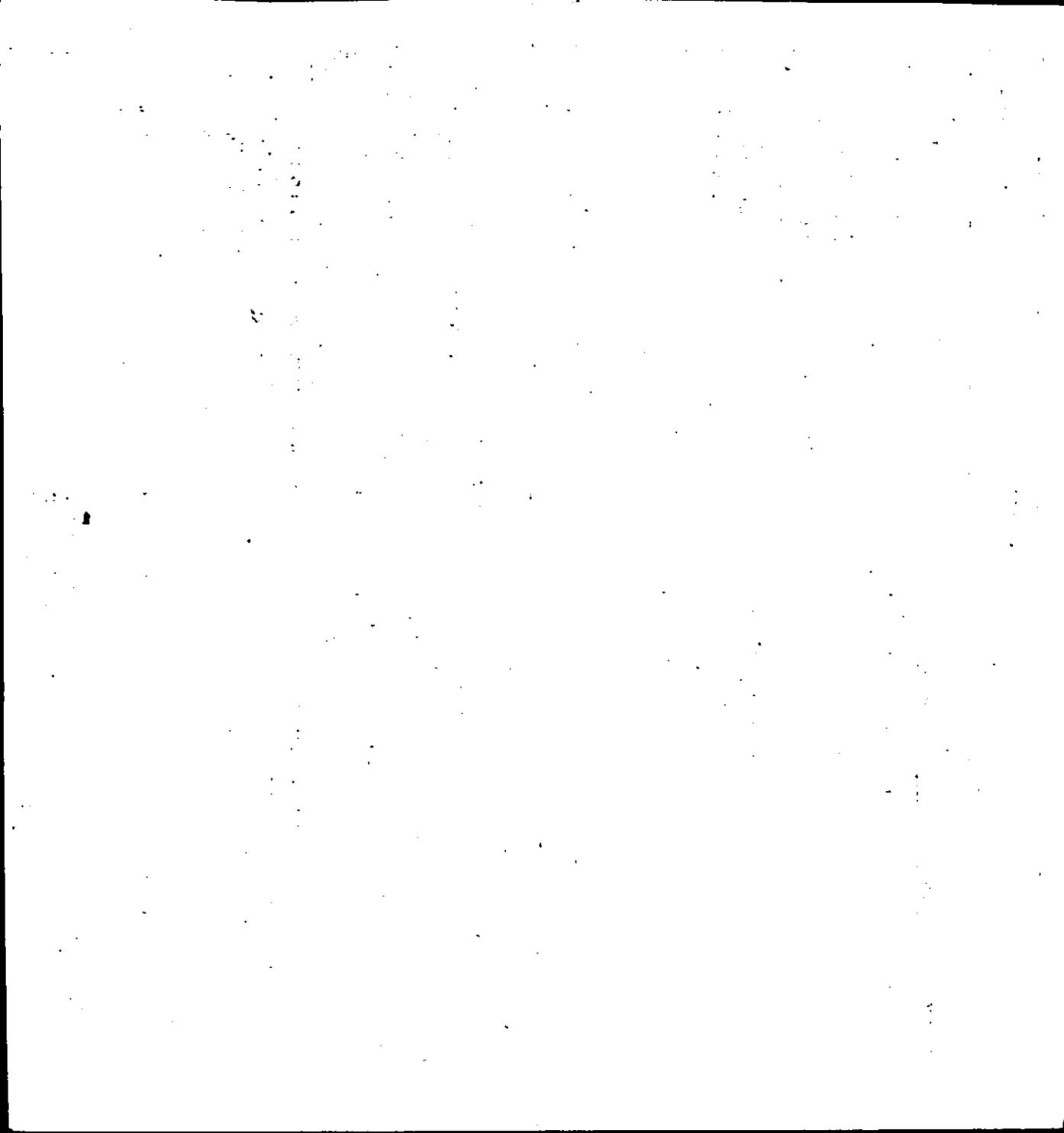
20. UNDERTAKER Thos. H. Beiderwieser ADDRESS 1936 St. Louis

1930

67

2350

23



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

ALL INFORMATION REQUESTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 784 File No.
 Township St. Ferdinand Primary Registration District No. 6630 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Kate Henrietta Gerbes

(a) Residence. No. St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Y 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-28-1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
✓ 68 X 10 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 2/10/1930 O. N. Schulte M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D. , 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

... is very important.

S-6198