

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

Do not use this space.

10994

1. PLACE OF DEATH

County.....
Township.....
City..... St. Louis, Mo. (No. *W. S. Marine Hosp*)

Registration District No. *791*
Primary Registration District No. *1003B*

File No.
Registered No. *3025*
St. Ward)

2. FULL NAME

Gerner Fred

(a) Residence. No. *830 S. 9th St.*, St. *21* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *53* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 1877*

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>53</i>		<i>Unknown</i>		

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *Common labor*
(c) Name of employer *Str. Erastus Wells.*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Charles Gerner*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Hattie Stellman*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

14.

INFORMANT..... *Mrs. J. H. ...*
(Address) *3640 Marine Ave., St. Louis, Mo.*

15.

FILED *Mar 25 1930* *W. S. Marine Hosp*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 24, 1930* 19

17.

I HEREBY CERTIFY, That I attended deceased from *March 22, 1930, 19* to *March 24, 1930, 19*, that I last saw him alive on *March 24, 1930*, 19, and that death occurred, on the date stated above, at *9:30 A.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Unknown.
131
132 B (duration) *3* yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Phenacetic Acid*
Septicemia (duration) *6* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *John Smith*, M. D.

(Address) *3640 Marine Ave., St. Louis, 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

DATE OF BURIAL

St. Matthews

March 1930

20. UNDERTAKER

ADDRESS

General Mortuary

215 Lafayette

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.

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

