

MAR 24 1931

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

Do not use this space.

1. PLACE OF DEATH

County *Franklin*
Township *Boeuf*
City (No.)

Registration District No. *292*
Primary Registration District No. *5410*

File No. *5101*
Registered No.
St. Ward

2. FULL NAME

Mrs Charlotte Gerdes

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *50* 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 *Female* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 26 - 1845*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 *5* *29*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *None*

(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) *Germany* *10*

10. NAME OF FATHER *Herm Stotman*

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

12. MAIDEN NAME OF MOTHER *Ann Koffelman*

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

14. INFORMANT *Aug. Grass*
(Address) *New Haven Mo*

15. FILED *7/16/31* *W. Heibel* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 15* 19*31*

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 10*, 19*31*, to *Feb 15*, 19*31* that I last saw h. *et* alive on *Feb 14*, 19*31*, and that death occurred, on the date stated above, at *8 a*. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11B

(duration) yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *10*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Chemical*

(Signed) *W. T. Eimbeck*, M. D.

2/16/31 (Address) *New Haven, 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

Boeuf Cem.

2-18 19*31*

20. UNDERTAKER

ADDRESS

L. B. Fertig *New Haven Mo*

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.

ON-PAIDING INK—THIS IS A PERMANENT RECORD

