

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.

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

Do not use this space.

APR 17 1935

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8737

1. PLACE OF DEATH

County Loscouche  
Township Boulevard  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 307  
Primary Registration District No. 5425

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Mary Amelia Johanna Gaerlich

(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct-10-1864</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>5</u>
	DAYS <u>28</u>	IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Owensville Mo

MOTHER FATHER 13. NAME Oscar Gaerlich

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Johanna Maria Hellmeyer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT W.F. Gaerlich  
(ADDRESS) St Louis Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Adkins Cove near DATE 3-7-1935

19. UNDERTAKER W.F. Gallenbacher  
(ADDRESS) Owensville Mo

20. FILED 3-4-1935 Mrs. F.B. Meyer  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-3-1935

22. I HEREBY CERTIFY, That I attended deceased from 2-20-1935, to 3-3-1935  
I last saw h alive on 3-2-1935. Death is said to have occurred on the date stated above, at 10 P m.

The principal cause of death and related causes of importance were as follows:  
Memia

Date of onset 2-20-35

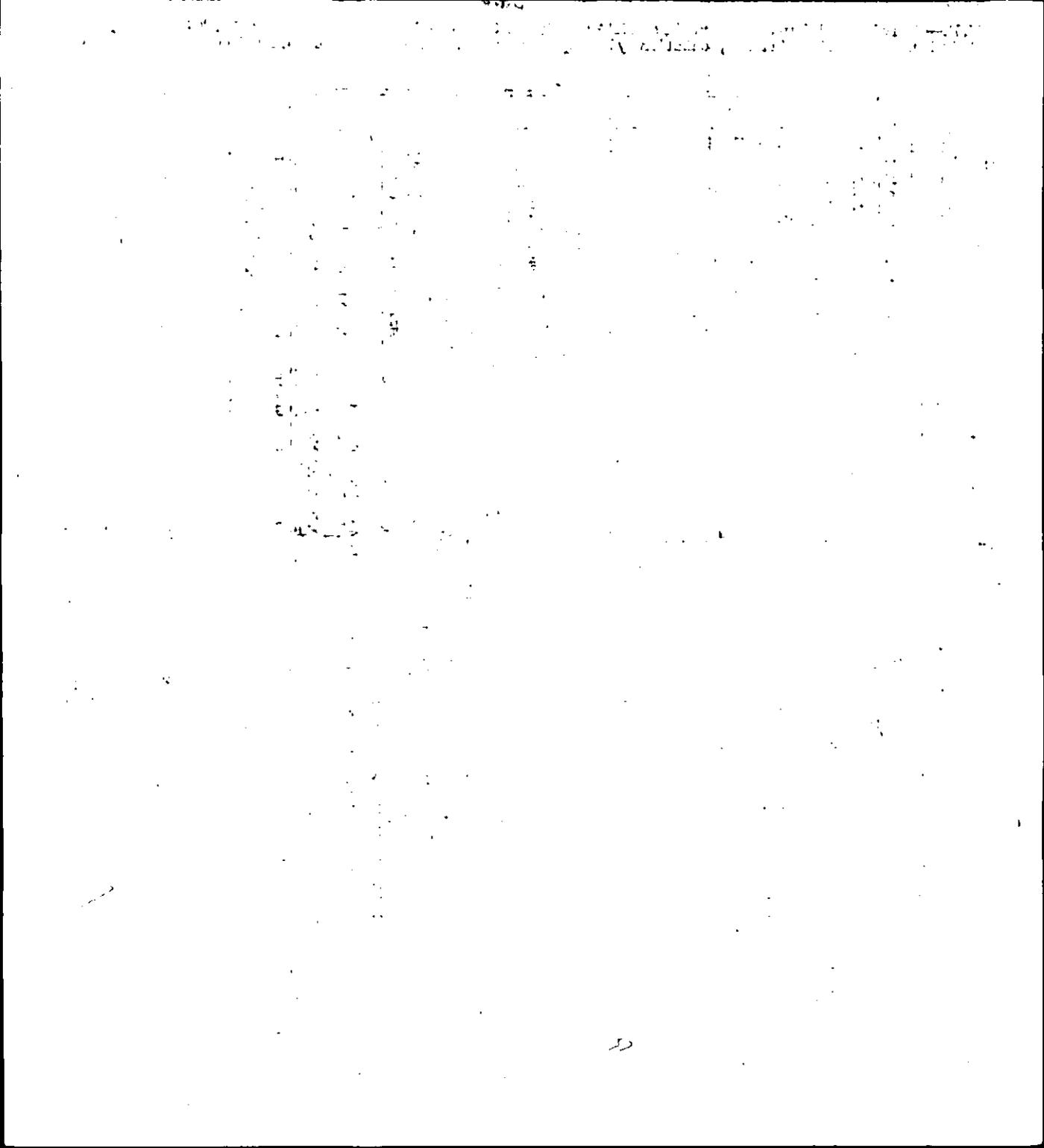
Other contributory causes of importance: 13!  
Rephritis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) Edna Mellies, M. D.  
(Address) Owensville Mo



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

Do not use this space.  
MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
ST. LOUIS, MO.  
FILE NO. \_\_\_\_\_  
REGISTERED NO. \_\_\_\_\_  
ST. \_\_\_\_\_ WARD \_\_\_\_\_

1. PLACE OF DEATH  
County Las Vegas Registration District No. 307  
Township \_\_\_\_\_ Primary Registration District No. 5425  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mary Amelia Gaebeck  
(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>71</u>	MONTHS <u>5</u>	DAYS <u>23</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	15. MAIDEN NAME			
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	17. INFORMANT (ADDRESS)			
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19__				
19. UNDERTAKER (ADDRESS)				
20. FILED <u>May-22</u> 19 <u>35</u> <u>Mrs. J.B. Meyer</u> Registrar.				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 3, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:  
Uremia acute  
Date of onset \_\_\_\_\_

Other contributory causes of importance:  
nephritis chronic

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Eelis Hellies, M. D.  
(Address) \_\_\_\_\_

SUPPLEMENTAL

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.

JUN 16 1933

JUN 28 1933

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