

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

Do not use this space.

JUL 29 1935

21830

1. PLACE OF DEATH

County Scott Registration District No. 820
 Township Lywanna Primary Registration District No. 6069
 City (No. St. Ward)

File No. _____
 Registered No. _____

2. FULL NAME

Benjamin Wm Gerst

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
— 10 6

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

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

10. NAME OF FATHER Clayton Gerst

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

12. MAIDEN NAME OF MOTHER Clara Gerbrack

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

14. INFORMANT Clayton Gerst
 (Address) Oran Mo

15. FILED 7/9 1935 J. H. Chmaw
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/21 1935

17. I HEREBY CERTIFY, That I attended deceased from Oran 6/21, 1935, to _____, 19____, that I last saw him alive on 6/21, 1935, and that death occurred, on the date stated above, at _____ 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enterocolitis

CONTRIBUTORY (SECONDARY) _____ (duration) _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ mos. _____ ds.

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. A. Chan, M. D.

19 (Address) Oran 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 _____

20. UNDERTAKER Catholic Cemetery 6/22 1935

ADDRESS none

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.

