

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

34149  
Do not use this space.

NOV 16 1938

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1008**  
 (c) City **St. Louis** (d) Street No. **De Paul Hospital** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Catherine M Gerke**

(a) Residence, No. **4659 Palm St** St. **10**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **The Late Frederick**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 1st 1869**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
**69 1 16**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**  
 9. Industry or business in which work was done, as 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) **Ireland 5**

FATHER 13. NAME **Pat Feeney**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland 5**

MOTHER 15. MAIDEN NAME **Unknown**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland 5**

17. INFORMANT **Fred Gerke**  
 (ADDRESS) **4659 Palm St**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Oct 21st 1938**

19. FUNERAL DIRECTOR (NAME) **Stroot - Carroll**  
 (ADDRESS) **4600 Natural Bridge Ave**

20. FILED **OCT 20 1938** **J. T. Bredeck**  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 17th 1938**

22. I HEREBY CERTIFY, That I attended deceased from **Oct 15**, 19**38**, to **Oct 17**, 19**38**  
 I last saw him alive on **Oct 17**, 19**38** Death is said to have occurred on the date stated above, at **1.10p**.  
 The principal cause of death and related causes of importance were as follows:

**Cerebral Hemorrhage** Date of onset **Oct 15/38**  
**Arterio Sclerosis**  
**Chronic Myocarditis**  
 Other contributory causes of importance **Indefinite**

Name of operation **Autopsy** Date of **Nov**  
 What test confirmed diagnosis? **Autopsy** 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? **no**  
 If so, specify **Harry D. Bruce** M. D.  
 (Signed) **Harry D. Bruce** (Address) **4903 Delmar**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Sheldon Collier*

Licensed Embalmer No.

3382

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.