

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  
STANDARD CERTIFICATE OF DEATH

Registration District No. **84**

Primary Registration District No. **117**

1. PLACE OF DEATH:  
 (a) County **St. Louis**  
 (b) City or town **Webster Groves**  
 (c) Name of hospital or institution: **650 Hollywood Pl.**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **None**  
 (Specify whether years, months or days)  
 In this community **83 years**

3. (a) PRINT FULL NAME **Louis F. Gerdelman 634**  
 8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. **none**  
 4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **Annie Gerdelman** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Sept. 25, 1856**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**83 1 10** hr. min.

9. Birthplace **St. Louis, Mo.**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Shoe worker**

11. Industry or business **Shoe factory**

12. Name **Unknown**

13. Birthplace **Unknown**

14. Maiden name **Unknown**

15. Birthplace **Unknown**

16. (a) Informant's own signature **Chas. Windsor**  
 (b) Address **650 Hollywood Pl.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-7-1939**  
 (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **Jay B. Smith**  
 (b) Address **7456 Manchester**

19. (a) **NOV 6 1939** (Data received local registrar) (b) **DR. Meyer** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **St. Louis**  
 (c) City or town **Webster Groves**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **650 Hollywood Pl.**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **5**  
 year **1939** hour **6** minute **20 A.** M.

21. I hereby certify that I attended the deceased from **Nov. 1, 1939** to **Nov 5, 1939**  
 that I last saw him alive on **Nov 3** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to **Cardiovascular**

Due to **Renal Disease**

Other conditions (Include pregnancy within 3 months of death) **(121)**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **J. J. Formally** (M. Director)

Address **Webster Groves** Date signed **11/7/39**

**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.....

Licensed Embalmer No. *4029*

P. O. Address..... *Maplewood*

**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.**