DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17300

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 4778

1. PLACE OF DEATH:
(a) County: Missouri
(b) City or town: St. Louis, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days) In this community: 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County:
(c) City or town: St. Louis, Mis (If outside city or town limits, write "RURAL") 13
(d) Street No.: City Infirmary (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Andrew Geiger
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Emma
6. (c) Age of husband or wife if alive: 53 years
7. Birth date of deceased: July (Month) 23 (Day) 1886 (Year)
8. AGE: Years 53 Months 10 Days 6 If less than one day hr. min.
9. Birthplace: Germany (City, town, or county) (State or foreign country)
10. Usual occupation: Plasterer retired 6 yrs
11. Industry or business:
FATHER 12. Name: Henry Geiger
13. Birthplace: Germany (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Barbara Carl
15. Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: John Geiger
(b) Address: 2430 Lemp Ave
17. (a) (Burial, cremation, or removal) (b) Date thereof: 6-1-40 (Month) (Day) (Year)
(c) Place: burial or cremation: SS Peter & Paul Cem.
18. (a) Signature of funeral director: G.H. Gelken & Sn. Co.
(b) Address: 2630 Gravois Av.
19. (a) MAY 31 1940 (Date received local registrar) (b) J. F. Burdeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th year 1940 hour 3:00 minute P. M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Crushed Skull suffered in jump from 3rd floor porch at City Infirmary	
Due to: Ground below May 29 @ 90 about 6:15 PM While	
Due to: Suffering from mental aberration	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

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): Suicide
(b) Date of occurrence: May 29 1940
(c) Where did injury occur? St Louis Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? City Infirmary (Specify type of place)
While at work? No (e) Means of injury: Jumpt out window
23. Signature: Alfred Gerl (M. D. or other)
Address: Respondent's home Date signed: 5/31/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Form 1-1-33 Rev. 1-1-33 X19511

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 Herman A. Gebken

Licensed Embalmer No. 2120

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.