

ED AUG 25 1940 791

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 2627 Montgomery
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town ST. LOUIS
(d) Street No. 2627 MONTGOMERY
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Josephine Gerber

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Chas. Gerber 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 7 1854
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER
12. Name Anthony Oberreither
13. Birthplace Germany
14. Maiden name Anna Schott
15. Birthplace Europe

16. (a) Informant Leo Gerber
(b) Address 4551 Lexington

17. (a) Burial (b) Date thereof 7/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director James H. Bopp
(b) Address 131 W. Argonne, Kirkwood

19. (a) JUL 1 1940 (b) J. F. Budick
(Date received from Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1940 hour 8:25 minute 4 M.

21. I hereby certify that I attended the deceased from _____, 1915, to June, 1940, that I last saw her alive on June 29, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Senility

Due to No other cause

Due to _____
Other conditions (include pregnancy within 3 months of death) 162

Major findings: Of operations _____
Of autopsy _____

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 Thos. M. Davis (M. D. or other) _____
Address 2422 N. Grand Date signed June 30

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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.....

Louis H. Bay, Registered Apprentice No.
working under my personal supervision.

Signed.....

Louis H. Bay
Licensed Embalmer No. *9201*

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.