

SEP 23 1940

Registration District No. 882

Primary Registration District No. 6174

Registrar's No. 12

1. PLACE OF DEATH

(a) County Warren
(b) City or town Victory Grove Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 2

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days 1 1/2

8. (a) PRINT FULL NAME Walter Leroy Gerdeman

3. (b) If veteran, name war _____
3. (c) Social Security No. none

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Aug 7 1935
(Month) (Day) (Year)

8. AGE: Years 5 Months 0 Days 17
If less than one day _____ hr. _____ min.

9. Birthplace Warren Co
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Walter P Gerdeman

13. Birthplace Lincoln Co
(City, town, or county) (State or foreign country)

14. Maiden name Mary L Gerdeman

15. Birthplace Warren Co
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter P Gerdeman
(b) Address Wright City Mo

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Nehring FHL Co
(b) Address Wright City Mo
19. (a) 8/27/40 (b) Julius Nehring
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. South of Wright City Mo
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
year 1940 hour 6 minute 50 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Crushed
Christ Abraham
Crushed

Due to Accidentally being hit by Wabash train

Due to falling
product of injury

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Aug 24

(c) Where did injury occur? Road crossing
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place
public highway
(Specify type of place) (e) Means of injury _____

23. Signature Dr F. H. King (M. D. or other)
Address Warrenton Mo Date signed Aug 24

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

Rev. 5-17-39

206M

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..... *Julius J. Beeburg*

Licensed Embalmer No. *3366*

P. O. Address *Wright City, Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29997**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **882**

Primary Registration District No. **6174**

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County **Warren**
(b) City or town **Rocky Grove T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Walter Le Roy Gerdman**
(b) If veteran, name war _____
(c) Social Security No. _____

4. Sex **m** 5. Color or race **w**
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ year _____ month _____ day

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **5** Months **0** Days **17**
If less than one day _____ hr _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **24**
year **1940** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Crushed chest at crossing**
accidental being hit by westbound train
with car being struck by train.
Due to _____
Other conditions **Occupant of car**
(Include pregnancy within 3 months of death)
Train and auto accident

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy **206 73**
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) **accidental**
(b) Date of occurrence **Aug 24-1940**
(c) Where did injury occur **R.R. Crossing**
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public House
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **Dr. F. P. ...** (M. D. or other) **D.C.**
Address **Warren, Mo.** Date signed **Aug 25**

SUPPLEMENTAL

