

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33543**
Registrar's No. **8250**

NOV 16 1940 **791**
Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saint Louis Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Infant Boy Gerken

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

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

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

7. Birth date of deceased September 22, 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>2</u> hr. <u>50</u> min.

9. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Glenn Paul Gerken

13. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Melba Cooper

15. Birthplace New Florence, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address 630 St. Highways Blvd

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof OCT 3 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Purpose

18. (a) Signature of funeral director H. H. Dept of Path.

(b) Address _____

19. (a) OCT 3 1940 (b) [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Saint Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 3936a Kennerly Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 22,
year 1940 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from September 22,
2:10 A.M., 19 40 to Sept. 22, 19 40
that I last saw him alive on Sept. 22, 1940 5:00 A.M.
and that death occurred on the date and hour stated above.

Immediate cause of death Remotely Duration _____

31 weeks gestation
Due to Placenta previa

Due to _____

Other conditions (Include pregnancy within 3 months of death) 51

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) _____

(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 [Signature] (M. D. or other) _____

Address _____ Date signed _____

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.

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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.....

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.