

No. 2
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42453**

JAN 15 1941

Registration District No. **1104**

Primary Registration District No. **5415**

Registrar's No. **19**

36

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town GERALD MO
(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 60 years
years, months or days) (Specify whether _____)

3. (a) PRINT FULL NAME EMIL F GERHLEN

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex male

5. Color or race white

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 10 23 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>2</u>	<u>22</u>	hr. _____ min.

9. Birthplace Union MO
(City, town, or county) (State or foreign country)

10. Usual occupation farming

11. Industry or business _____

12. Name HENRY GERHLEN

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

14. Maiden name ELISE MARIE STAN
(City, town, or county) (State or foreign country)

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

16. (a) Informant Edna Fischer

(b) Address GERALD MO

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 12-16-40
(Month) (Day) (Year)

(c) Place: burial or cremation Smith Comatary

18. (a) Signature of funeral director E. Meyer

(b) Address Gerald mo

19. (a) _____
(Date received local registrar)

(b) _____
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Franklin

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

(d) Street No. Rural
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1940 hour 12 minute P M.

21. I hereby certify that I attended the deceased from Jan, 1938 to Dec 15, 1940
that I last saw him alive on Dec 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to _____

Other conditions (Include pregnancy within 5 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) _____

(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? _____

23. Signature Charles A. Schmidt (M. D. or other)

While at work _____ (Specify type of place)
or by means of injury _____

*Address Gerald MO Date signed 12/15/40

Duration 7 hrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address Owensville, 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.

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Registration District No. 1104

Primary Registration District No. 5415

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Boone
(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

Emil F Gerken

3. (b) If veteran, name war

3. (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 years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

60

1

22

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

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)

(Date received local registrar)

(b)

Chas A Schmidt
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Boone Ia
(If outside city or town limits write "RURAL")

(d) Street No. Rural Station
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1900 hour minute 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.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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 Chas A Schmidt (M. D. or other)

Address Gerald Date signed

SUPPLEMENTARY

