

15709

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

AY 16 1946  
District No. ....

Primary Registration District No. 3038

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall, Mo.  
(c) Name of hospital or institution:  
Fitzgibbon Hospital  
(d) Length of stay: In hospital or institution About 3 weeks  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton  
(c) City or town Brunswick, Mo.  
(d) Street No. Broadway  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 1  
year 1942 hour 6 minute 45 P. M.  
21. I hereby certify that I attended the deceased from  
Mar. 7 1942 to Apr. 1 1942  
that I last saw him alive on Apr. 1 1942  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME William Joseph Gerhart

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 Single

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

7. Birth date of deceased July 31 1891  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days - If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business Seed Store

12. Name George Gerhart

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

14. Maiden name Virginia DeMars

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

16. (a) Informant Vivian Gerhart

(b) Address Waco Texas

17. (a) Burial place Brunswick (b) Date thereof Apr. 7, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brunswick, Mo.

18. (a) Signature of funeral director J. Leslie Bunn  
(b) Address Marshall, Mo.

19. (a) Date received local registrar Apr 23/42 (b) (Registrar's signature)

Immediate cause of death  
Acute pulmonary edema  
Due to Chronic myocarditis  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

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

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  
3. Signature J. Leslie Bunn (M. D. or other)  
Address Marshall, Mo. Date signed 4-3-42

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

MOTHER FATHER

12/15

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed

5-15-42

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

*J. Leali Surratt*

Licensed Embalmer No.

3235

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-709

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall  
(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 William Gerhart  
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: July 31 1877  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 4/3/42 (Date received local registrar) (b) M. O. Oberholtzer (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr Day \_\_\_\_\_ Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

1942

S-15709