

FILED NOV 30 1944

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35898

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9741

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST. LUKE'S HOSPITAL  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town ROLLA  
(If outside city or town limits, write "RURAL")  
(d) Street No. Box # 550  
(If rural, give location) N.R.  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME INFANT BOY GERBER

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 Nov. 11 1944  
(Month) (Day) (Year)

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

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

10. Usual occupation INFANT

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name CARROLL GERBER

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

14. Maiden name HELEN WADE

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

16. (a) Informant Carroll Gerber  
(b) Address Rolla, Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 16, 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation LAKE CHARLES CEM

18. (a) Signature of funeral director J. F. Brueck

(b) Address 516 S. Delmar Bl

19. (a) NOV 16 1944 (Date received local registrar) (b) J. F. Brueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 11th year 1944 hour 5 minute 55 P.M.

21. I hereby certify that I attended the deceased from NOV. 11, 1944 to NOV. 11, 1944, 19\_\_\_\_, that I last saw him alive on NOV. 11, 1944, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Intra cranial hemorrhage

Due to 1/100

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsies Intra cranial hemorrhage

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 Clarence Kufner (M. D. or other)

Address 3720 Washington Date signed 11-16-44

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

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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 No Embalming, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

H. G. Farris  
Licensed Embalmer No. 3384  
P. O. Address St. Louis

**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.**