

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 9 1944

1003

Registration District No. 318

Primary Registration District No. _____

Registrar's No. 10183

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

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Greene
(c) City or town Eldred
(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 _____

3. (a) PRINT FULL NAME Gerald Eugene Johnisee

3. (b) If veteran, name war Nil 3. (c) Social Security No. Nil

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 November 1 1938
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 0 26 hr. min.

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

10. Usual occupation Child

11. Industry or business _____
12. Name Emmert Johnisee

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

14. Maiden name Mary Varble
15. Birthplace Calhoun Co. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Emmert Johnisee
(b) Address Eldred, Ill.

17. (a) Removal (b) Date thereof 11-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eldred, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 29 1944 J. F. Mueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27
year 1944 hour 6:40 minute P. M.

21. I hereby certify that I attended the deceased from
Nov. 15, 1944 to Nov. 27, 1944
that I last saw him alive on Nov. 27, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis meningitis Duration 3 wks.

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 T. S. Zahorsky (M. D. or other) M.D.
Address 536 N. Taylor Date signed 11/28/44

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.....

John G. ...
.....

Licensed Embalmer No. *3398*.....

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.