

FILED MAY 3 1945
 Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8556**

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Deaconess 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

3. (a) PRINT FULL NAME Rev. John W. Gaebe

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

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

6. (b) Name of husband or wife Emma Gaebe 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December 2 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>4</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation Minister

11. Industry or business _____

MOTHER FATHER { 12. Name William Gaebe
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Gaebe
 (b) Address Rt. 3, Farmington, Mo.

17. (a) Burial (b) Date thereof April 23, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul's Churchyard

18. (a) Signature of funeral director C. Hoffmeister & L. Co.

(b) Address 7814 S. Broadway

19. (a) APR 22 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Farmington
(If outside city or town limits, write "RURAL")
 (d) Street No. Routen #3
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
 year 1945 hour 10 minute 05 P.M.

21. I hereby certify that I attended the deceased from Feb 20
 _____, 1945, to April 20, 1945
 that I last saw him alive on April 20, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death
Thrombophlebitis
Infarct Wren Coast
 Due to Thrombophlebitis
Left femoral vein for 3 weeks
 Due to _____
 Other conditions Hypertrophied Prostate
(Include pregnancy within 3 months of death)

Duration
<u>3 weeks</u>
<u>5 yr.</u>

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings: Prostatectomy
 Of operations for Hypertrophied Prostate
 Of autopsy 3-25-45

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 G. R. Sheffer (M. D. or other) _____
 Address 1020 Mo. North Bldg Date signed 4-2-45

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 Linus C. Hoffmeister

Licensed Embalmer No. 2817

P. O. Address 7814 S. Broadway

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.