V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 7 1945

State File No. 24965

Registration District No. 317 Primary Registration District No. 2070 Registrar's No. 1886

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

76
7
4

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1215 S. Berry Rd. 1
(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 Illinois (b) County Green 999
(c) City or town Carrollton 11
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME John Henry Geers

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

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 9 (Day) 1874 (Year)

8. AGE: Years 71 Months 4 Days 18 If less than one day hr. min.

9. Birthplace Carrollton (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Clerk - Retired
11. Industry or business

FATHER
12. Name Herman Geers
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Helen Snydehahn
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 4

16. (a) Informant Mrs. Elizabeth Pranger
(b) Address 1215 S. Berry Rd.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Carrollton, Ill.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 7-30-45 (Date received local registrar) (b) E. G. McGovran M.D. (Registrar's signature) MS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1945 hour 12:05 minute P. M.

21. I hereby certify that I attended the deceased from Oct 25, 1944, to July 27, 1945; that I last saw him alive on July 27, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Heart failure	2 dys
Due to: Chr. myocarditis	1 yr
Due to: Chr. Interstitial nephritis	1 yr
131a	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) M.D.
Address 4937 Maryland Date signed 7/28/45

707

(Licensed Embalmer's Statement on Reverse Side)

AUG 7 1945

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 Elliott G. Hoppe

Licensed Embalmer No. 2971

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.