S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25661

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 7414

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL NO 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 009
(c) City or town St Louis (If outside city or town limits, write "RURAL") 17 24
(d) Street No. 2635 Keokuk (If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES W GEBHART
3. (b) If veteran, name war
3. (c) Social Security No. 494-07-5617

4. Sex Male 1
5. Color or race White
6. (a) Single, widowed, married, Married 1
6. (b) Name of husband or wife Adrienne Gebhart
6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased April 2nd (Month) 1893 (Day) (Year)

8. AGE: Years 52 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace St Louis Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation Brewery Worker
11. Industry or business

MOTHER FATHER
12. Name James Gebhart
13. Birthplace Indiana (City, town, or county) 1 (State or foreign country)
14. Maiden name Amanda Lape
15. Birthplace Indiana (City, town, or county) 1 (State or foreign country)

16. (a) Informant Adrienne Gebhart
(b) Address 2635 Keokuk St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/45 (Month) (Day) (Year)
(c) Place: burial or cremation SUNSET BURIAL PARK
18. (a) Signature of funeral director Thoenitz & Son
(b) Address 2906 Gravois Ave.
19. (a) AUG 27 1945 (Date received local registrar) (b) J. F. Bridek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1945 hour 7 40 A.M. minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Skull by Fall Hemorrhage of Brain while he was Lying Paralytic and fell down from

Due to Wooden steps with concrete walls at his home 2635 Keokuk

Due to Aug. 15, 1945 about 9:45 PM

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

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) Accident
(b) Date of occurrence Aug 15 1945
(c) Where did injury occur? St Louis (City or town) (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? (e) Means of injury Fall.
23. Signature Alfred Perry M.D. (M.D. or other)
Address Date signed 8/27/45

(Licensed Embalmer's Statement on Reverse Side)

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 Virgil L. Berryman

Licensed Embalmer No. 4018

P. O. Address St. Louis, Mo

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.