

FILED OCT 6 1945

Registration District No. **217**

Primary Registration District No. **2002**

Registrar's No. **2315**

1. PLACE OF DEATH:
 (a) County Missouri **ST. LOUIS**
 (b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
7060 Julian Avenue
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 19 years
years, months or days)

3. (a) PRINT FULL NAME Mr. George Gerdes

3. (b) If veteran, name war _____ **3. (c) Social Security** No. 495-18-3173

4. Sex <u>Male</u> 0	5. Color or race <u>White</u>	6. (a) Single, widowed, married, divorced <u>Married</u>
6. (b) Name of husband or wife <u>Margaret Hillman</u>	6. (c) Age of husband or wife if alive <u>67</u> years	
7. Birth date of deceased <u>August 22, 1876</u> <small>(Month) (Day) (Year)</small>		

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>1</u>	<u>11</u>	---hr. ---min.

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

10. Usual occupation Painter

11. Industry or business Painting

12. Name Christian Otto Gerdes

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

14. Maiden name Elizabeth Schuster

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

16. (a) Informant Mrs. Margaret Gerdes

(b) Address 7060 Julian

17. (a) Cremation _____ **(b) Date thereof** Oct. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) Address 1936 St. Louis Ave.

19. (a) 10-4-45 **(b)** E. S. M. Garrison, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town University City
(If outside city or town limits, write "RURAL")
 (d) Street No. 7060 Julian
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3rd
 year 1945 hour 8:15 minute A M.

21. I hereby certify that I attended the deceased from 9-28-45
 _____, 19____, to 10-3-45, 19____;
 that I last saw him alive on October 2-45, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Thrombosis
Angina Pectoris
 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) Manner of injury _____
23. Signature Otto C. Hansen, M.D.
(St. D. or other)
 Address 315 79 Parker Date signed 10/3/45

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

76
3
5

MOTHER FATHER

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

NOV 16 1945

APR 30 1952

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.

No Embalming

Signed.....

Licensed Embalmer No.....

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.