

S. No. 2
M-5-42
v. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

39193

State File No.

Registrar's No. 11241

FILED JAN 31 1945
Registration District No.

Primary Registration District No.

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:
2823 Texas Ave
(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 Louisa Gleasmann
3. (b) If veteran, name war *****
3. (c) Social Security No. *****

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased March 8 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>9</u>	<u>12</u>	..hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

MOTHER FATHER {
12. Name August Gerecke
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Frieda Kuhn
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Wesman Gerecke
(b) Address 3308 Louisiana Ave

17. (a) Burial (b) Date thereof 12-22-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Ziegler & Co
(b) Address 6409 Gravois Ave

19. (a) DEC 22 1945 (b) J. F. Bredenk
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2823 Texas Ave
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20th day December
year 1945 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from
Oct. 10, 1945 to Dec 20, 1945
that I last saw her alive on Dec 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Coronary Embolism
Due to Coronary Thrombosis
Due to Myocarditis etc.
Other conditions Hypertension
(Include pregnancy within 3 months of death)

Duration
1 day
4 mos.
1 yr.

Major findings:
Of operations none
Of autopsy none

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?

While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature J. F. Bredenk (M. D. or other) md
Address 2767 Kansas Date signed 12-21-45

Dr. Donohof
California - Bureau
2767 Broadway Ave

173
Pro - 0310

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..... *Homer W. Prity*

Licensed Embalmer No. *3882*

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.