

FILED OCT 28 1946

State File No.

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 399

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bothwell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo. 7 da.
(Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Benton 8
(c) City or town Cole Camp 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Louise Gerken

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

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

6. (b) Name of husband or wife Cord Gerken 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased December 24th 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Munsterman
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Gerken
(b) Address Cole Camp Mo

17. (a) Burial (b) Date thereof Oct 16th 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Paul Cemetery

18. (a) Signature of funeral director E. K. Eickhoff

(b) Address Cole Camp

19. (a) 10-14-46 (b) Betty Yeager
(Date received local registrar) (Registrar's signature)

251 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13
year 1946 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from July 6 1946 to Oct 13 1946
that I last saw h. alive on Oct 13 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 2 wks

Due to Chronic myocarditis + shock 3 weeks

Due to Fracture of head of left humerus. 3 months

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following: 8

(a) Accident, suicide, or homicide (specify) Car

(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? _____ (Specify type of place) Means of injury _____

23. Signature Wm D. O'Hara M. D. (other) _____
Address Sedalia Mo Date signed 10/17/46

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-26-66

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 E. F. Eickhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalea
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Louise Gecker

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased see 24 (Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 186A 78

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) accident
(b) Date of occurrence 7-6-46
(c) Where did injury occur? her home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? yard of home, tripped on long grass (Specify type of place) While at work? no (e) Means of injury fall

23. Signature C.D. Shorne (M. D. or Other) _____

Address _____ Date signed 11/6/46

WHITE PAPER - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

SUPPLEMENTARY

3316

34343