

S. No. 2
-12-45
5-17-39
P I X47070

FILED MAR 24 1947
318

Registration District No. Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max. C. Spahrloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... **60 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **add**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5512 ORIOLE**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **MARY GERDING**
3. (b) If veteran, name war..... 3. (c) Social Security No.
4. Sex **Fe** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **HY. E. GERDING**
6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **Nov 23 1874**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **10th**
year **1947** hour **7:15** minute **A** M.
21. I hereby certify that I attended the deceased from **2/12/47**
....., 19....., to **3/10/47**....., 19.....;
that I last saw her alive on **3/10/47**....., 19.....;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 3 17 hr. min.

Immediate cause of death **Diabetes Mellitus**
Bronchopneumonia
Due to **61**
Due to

9. Birthplace **GERMANY** (City, town, or county) (State or foreign country)
10. Usual occupation **AT HOME**

Other conditions **Atrophy of Pancreas**
(Include pregnancy within 6 months of death)
Major findings of operation **Chronic passive congestion of liver**
Bilateral nephrosclerosis
and Hydronephrosis
Of autopsy **Chronic interstitial nephritis**
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business
12. Name **HY MEIER**
13. Birthplace **GERMANY** (City, town, or county) (State or foreign country)
14. Maiden name **MARIE BREWER**
15. Birthplace **GERMANY** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hy C. Adams**
(b) Address **5512 Oriole**
17. (a) **BURIAL** (b) Date thereof **3-13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **NEW BETHLEHEM**

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?

18. (a) Signature of funeral director **Perseus van Junsthorpe**
(b) Address **1936 St. Louis**
19. (a) **MAR 13 1947** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

While at work? **St. Louis** (Specify type of place) (e) Means of injury
23. Signature **J. F. Bredeek** 3/10/47
Address..... Date signed.....

3-10-47

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

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 *Delis J. Krupin*
Licensed Embalmer No. *3497*
P. O. Address *1936 St. Louis Ave*

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.