FILED NOV 19 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40483

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10324

1. PLACE OF DEATH
a. COUNTY: 2157
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 10 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Alexian Bros Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: 0
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2907 Mt. Pleasent

15

3. NAME OF DECEASED (Type or Print)
a. (First): Rudolph
b. (Middle):
c. (Last): Gering

4. DATE OF DEATH (Month) (Day) (Year): 10-28-53

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 13 1912

9. AGE (In years last birthday): 40 — If under 1 year: Months | Days — If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metal Spiner Own

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and State or Foreign Country): Germany

12. CITIZEN OF WHAT COUNTRY?: 4

13a. FATHER'S NAME: Rudolph Gering Sr

13b. MOTHER'S MAIDEN NAME: Marie Ehmig

14. NAME OF HUSBAND OR WIFE: Elsa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Naval — (If yes, give war or dates of service): Reserve

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Elsa Gering 2907 Mt. Pleasant

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of Jejunum with Metastases.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: 152X

22. *I hereby certify that I attended the deceased from* July 1, 1953, *to* Oct. 28, 1953, *that I last saw the deceased alive on* Oct. 27, 1953, *and that death occurred at* 6:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William M. Komanetsky, MD

23b. ADDRESS: 6400 Morganford Rd.

23c. DATE SIGNED: 10-30-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 10/31/53

24c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park

24d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

DATE REC'D BY LOCAL REG.: OCT 30 1953

REGISTRAR'S SIGNATURE: J. Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. Schumacher 3013 Meramec

(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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Jack Haupt

Licensed Embalmer No. 4746

P. O. Address St Fair

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

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