

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10052

State File No. ....

FILED MAR 19 1954  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2194

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2169	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> 0
d. FULL NAME OF HOSPITAL OR INSTITUTION ALEXIAN BROS. Hosp. 16		e. STREET ADDRESS (If rural, give location) 3640 HARTFORD	

3. NAME OF DECEASED (Type or Print) a. (First) JULES b. (Middle) H. c. (Last) GERARD			4. DATE OF DEATH (Month) (Day) (Year) MAR. 8 1954		
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5. SEX MALE	6. COLOR (OR RACE) WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH APRIL 25 1892	9. AGE (in years last birthday) 61	10. MONTHS	11. YEAR	12. HOURS	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MEDICAL DOCTOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME JOHN B. GERARD		13b. MOTHER'S MAIDEN NAME JENNIE EILERS		14. NAME OF HUSBAND OR WIFE UNKNOWN	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ROSALIE GRACE 3640 HARTFORD		ADDRESS	
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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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, T. Ho				INTERVAL BETWEEN ONSET AND DEATH 5 1/2	
		ANTECEDENT CAUSES Ch. Abscess of Lung				1 1/2	
		DUE TO (c) Infarction				3 2/3	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paralytic Atony				2 2/3	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 490X				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 8/22, 1954 to 8/27, 1954, that I last saw the deceased alive on March 8, 1954 and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE Edward J. ...		23b. ADDRESS 607 The Grand		23c. DATE SIGNED 3/9/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR. 11 1954	24c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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DATE REC'D BY LOCAL REG. MAR 9 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis 2906 Garrison	ADDRESS
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WRITE PLAINLY—USING 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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Homer C. Dil*.....

Licensed Embalmer No. *434*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.