

Dept. Health,
c., & Welfare
S. Public
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FILED NOV 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42924
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2734

V. S. 300
Rev. 11-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>38 Maryhurst Normal</u>		Length of stay in lb <u>2 mos.</u>	d. STREET ADDRESS (If outside, give location) <u>1909 N. Kingshighway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Gediohn</u>			4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1877</u>
9. AGE (In years last birthday) <u>79</u>		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) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious Order</u>	11. BIRTHPLACE (City and state or country) <u>Vandsbek Hamburg, Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Gediohn</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Schuster</u>		14. NAME OF HUSBAND OR WIFE <u>Never married.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Maryhurst Normal, 1101 So. Lindbergh</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Deкомпensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>420.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Pyelitis; Chronic Bronchitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY : STATE
21. I attended the deceased from <u>Feb 1941</u> to <u>Nov. 1957</u> and last saw her/him alive on <u>Nov. 1, 1957</u> Death occurred at <u>1:00</u> pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>P. D. Cassidy / R. M. Launch M.D.</u>		22b. ADDRESS <u>4952 Maryland</u>	22c. DATE SIGNED <u>2 Nov. 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 4, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maryhurst Normal</u>	23d. LOCATION (City, town, or county) (State) <u>Kirkwood, Missouri</u>
24. FUNERAL DIRECTOR <u>Hoffmeister</u> ADDRESS <u>Colonial Mortuary, 6464 Chippewa St.</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert A. Donke</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

27.

Launch
495x Maryland

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 *Lisina C. Hoffmeier*

Licensed Embalmer No. *3891*

P. O. Address *7814 J. Breed*

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.