

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023313

STATE FILE NUMBER

6202

FILED JUL 1 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN Saint Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 81 5727 Southwest Avenue		d. STREET (If outside, give location) ADDRESS 2/39 5727 Southwest Ave	
3. NAME OF DECEASED (Type or print) First Adolph (Otto) A/K/AS Middle Last Gerke		4. DATE OF DEATH Month 6 Day 17 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City St. Louis, Mo	11. BIRTHPLACE (City and state or country) Mt. Olive, Ill.
13a. FATHER'S NAME Frederick Gerke		13b. MOTHER'S MAIDEN NAME Lydia Swing	14. NAME OF HUSBAND OR WIFE A/K/AS Katherine (Kate) Gerke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 499 01 7905	17. INFORMANT Katherine (Kate) Gerke Nee Flickinger
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF ABDOMINAL AORTIC ANEURYSM DUE TO (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451X			INTERVAL BETWEEN ONSET AND DEATH 12-14 HRS YEARS
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.) 451X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1956 to 6-17-58 and last saw him alive on 6-10-58 Death occurred at About 7:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frederick W. Henig, M.D.		22b. ADDRESS 16 Hampton Village Place	22c. DATE SIGNED 6-18-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-20-1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ADDRESS Hoefmeister Colonial Mortuary 6464 Chippewa Street, St. Louis 9, Mo		25. DATE RECD. BY LOCAL REG. JUN 18 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.

S. 300
1-57

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

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 *L. C. Branson*

Licensed Embalmer No. *4764*
P. O. Address *St. Louis*

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.