Health, & Welfare Public Service

. 300 0
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-025492
STATE FILE NUMBER

FILED AUG 8 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3517

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTH. HOSP — Length of stay in 1b: 1 WEEK

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE TEXAS b. COUNTY HIDALGO
c. CITY OR TOWN DONNA 8 42 08 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) NONE — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First CARL Middle (NONE) Last GERBER

4. DATE OF DEATH Month July Day 18 Year 1958

5. SEX MALE 0

6. COLOR OR RACE WHITE

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] 2 **DIVORCED** [ ]

8. DATE OF BIRTH —

9. AGE (In years last birthday) 66 — 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) RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) SWITZERLAND 4

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JACOB GERBER

13b. MOTHER'S MAIDEN NAME MARIE WAITZER

14. NAME OF HUSBAND OR WIFE MABEL GERBER

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

16. SOCIAL SECURITY NO. NONE

17. INFORMANT OTTO GERBER Address STEWARTVILLE, MINN.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chr Myocarditis — 3 yrs
DUE TO (c) Chr Nephritis — 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) NO
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year NO
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 July 1, 1958, to July 18, 1958 and last saw her/him alive on July 18, 1958
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. B. Casebolt (Degree or title) MD
22b. ADDRESS 4000 Baltimore KC Mo
22c. DATE SIGNED 7-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE July-19-1958
23c. NAME OF CEMETERY OR CREMATORY DONNA CEMETERY
23d. LOCATION (City, town, or county) DONNA, TEXAS (State)

24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS — **ADDRESS** KANSAS CITY, MO
25. DATE RECD. BY LOCAL REG. 7-19-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

M. B. Casebolt

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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K.C. Mo.

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.