Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-034244
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8596

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 04 BARNES HOSPITAL — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: St. Clair
c. CITY OR TOWN: 3/20 St.Rt.159 lmi.S.Collinsville — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 32 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CHRIS Middle: NMN Last: GERHARD
4. DATE OF DEATH: Month, Day, Year: SEPTEMBER 5, 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1893
9. AGE (In years last birthday): 65 — 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): Butcher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Belleville, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: William Gerhard
13b. MOTHER'S MAIDEN NAME: Josephine Vratney
14. NAME OF HUSBAND OR WIFE: deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.#1
16. SOCIAL SECURITY NO.: none
17. INFORMANT: William Gerhard Address: Belleville, Illinois

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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) Carcinoma of larynx with metastasis to brain — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 161x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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 2/11/53, to 9/5/58 and last saw him alive on 9/5/58
Death occurred at 2:12 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F R Bradley (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 9/5/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 9-8-58
23c. NAME OF CEMETERY OR CREMATORY: Mt.Hope Cemetery
23d. LOCATION (City, town, or county) (State): Belleville, Illinois

24. FUNERAL DIRECTOR: Chas.M.Burke ADDRESS: E.St.Louis, Illinois
25. DATE RECD. BY LOCAL REG.: SEP 5 '58
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(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 ..... Signed Chas M Burke

Signature of Student Embalmer

Licensed Embalmer No. 2421

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.