

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041601

STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10806

300
1-57

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|--|----------------------------------|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Jennings, | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION New Faith Hospital | | Length of stay in lb 9 Days | d. STREET ADDRESS (If outside, give location) 8715 Agate Court | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Gerken Last Gerken | | | 4. DATE OF DEATH Month November Day 9 Year 1958 | | | |
| 5. SEX Male <input type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 9, 1892 | 9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Gardner | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Herman Gerken | | 13b. MOTHER'S MAIDEN NAME Maria Meising | | 14. NAME OF HUSBAND OR WIFE Elsie Gerken, (Deceased) | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Belleville Ill. Mrs Robert V. Newsome, 204 Longview Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma. | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 d. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinosis of Liver | | | | | 5 yrs. | |
| DUE TO (c) Pyloric Obstruction | | | | | 2 wks. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 581.0 | | | | | 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --- | | | |
| 20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | | |
| 21. I attended the deceased from 1940 to 11/9/58 and last saw him alive on 11/9/58 Death occurred at 10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE H. J. Stein (Degree or title) MD | | | 22b. ADDRESS 6917 W. Flouissant | | 22c. DATE SIGNED 11/10/58 | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE 11-11-1958 | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Math. Hermann & Son Inc. 2161 E. Fair Ave. | | | 25. DATE RECD. BY LOCAL REG. NOV 10 58 | 26. REGISTRAR'S SIGNATURE Carl Smith MD mcb | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Arthur W. Hayes*

Licensed Embalmer No. *3737*

P. O. Address *G. Lane*

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.