

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047128

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6227

300
1-57

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital | | Length of stay in lb 69 yrs | d. STREET ADDRESS (If outside, give location) 6119 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First MRS. NORA Middle GERLING Last GERLING | | | 4. DATE OF DEATH Month December Day 30 Year 1958 | | |
|--|--|--|--|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|---|--|--|--|
| 5. SEX Female | 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 Aug 24, 1889 | 9. AGE (In years & birth day) 69 | 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) Music Teacher | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | 11. BIRTHPLACE (City and state or country) Kansas City Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|--|--|---|

| | | |
|--|---|--|
| 13a. FATHER'S NAME Fred T. Lueth | 13b. MOTHER'S MAIDEN NAME Katie Braun | 14. NAME OF HUSBAND OR WIFE Arthur Gerling |
|--|---|--|

| | | |
|---|-------------------------------------|--|
| 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. — | 17. INFORMANT Mrs. Wm. Schutt Address 6117 Forest |
|---|-------------------------------------|--|

| | | |
|--|-------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reynold's Disease of the brain | | INTERVAL BETWEEN ONSET AND DEATH Several hours Seven min few minutes |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Myocardial damage | |
| DUE TO (c) Phudias Ament Secordy | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH by 4530 | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <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 Nov. 17, 58 to Dec. 30, 58 and last saw her alive on Dec. 30, 1958 Death occurred at — m on the date stated above; and to the best of my knowledge, from the causes stated. |
|---|

| | | |
|--|--------------------------------------|-------------------------------------|
| 22a. SIGNATURE [Signature] (Degree or title) | 22b. ADDRESS 3939 Prospect | 22c. DATE SIGNED 12-31-58 |
|--|--------------------------------------|-------------------------------------|

| | | | | |
|--|----------------------------|--|---|-----------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-3-59 | 23c. NAME OF CEMETERY OR CREMATORY Mt Moriah | 23d. LOCATION (City, town, or county) Kansas City | (State) Mo. |
|--|----------------------------|--|---|-----------------------|

| | | |
|--|---|---|
| 24. FUNERAL DIRECTOR Stine & McClure ADDRESS K.C. Mo. | 25. DATE RECD. BY LOCAL REC. 12-31-58 | 26. REGISTRAR'S SIGNATURE [Signature] |
|--|---|---|

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. Atcheson

MEDICAL CERTIFICATION

004.7.6110

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 *J. S. Walton*

Licensed Embalmer No. *2744*

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.