

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010938

STATE FILE NUMBER

2456

FILED MAR 30 1959

Registration District No.

Primary Registration District No.

Registrar No.

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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) TOWN St. Louis		c. CITY OR TOWN Pagedale 4281	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospt		d. STREET ADDRESS (If outside, give location) 1226 Griefield Pl.	
3. NAME OF DECEASED (Type or print) First Hebert Middle F Last Gemke		4. DATE OF DEATH Month March Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		11. BIRTHPLACE (City and state or country) St. Louis Missouri	9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY Mfg.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Gemke		13b. MOTHER'S MAIDEN NAME Anna Peil	14. NAME OF HUSBAND OR WIFE Leona Gemke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 490 01 0266	17. INFORMANT Address Leona Gemke 1226 Griefield Pl.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage rt side. diabetes mellitus DUE TO (b) a.s. H. D. DUE TO (c) 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2/2 mos. 10 yrs
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. 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 12-27-58 to 3-8-59 and last saw her alive on 3-8-59 Death occurred at 10:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. W. Smith M.D.		22b. ADDRESS 8321 N Broadway	22c. DATE SIGNED 3-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
Burial		3-11-59	Calvary Cemetery
24. FUNERAL DIRECTOR J.W. Clark		25. DATE RECD. BY LOCAL REG. MAR 10 '59	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
ADDRESS F.H. 1125 Hodiament Ave		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Lawrence O. Gerling*

Licensed Embalmer No. *4979*

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.