Health, Welfare Public Service

300 -57 0 3

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015000

STATE FILE NUMBER

FILED MAY 12 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4146

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3329 a ILLINOIS — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3329 a ILLINOIS — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: CHARLES L. GERDES

4. DATE OF DEATH Month Day Year: APRIL 26 1959

5. SEX: MAle

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 22 1876

9. AGE (In years last birthday): 82 — 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 SHOE WORKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Mo

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

13a. FATHER'S NAME: BERNARD GERDES

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF ~~HUSBAND~~ OR WIFE: ANN GERDES

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.: 492-01-7211

17. INFORMANT: ANN GERDES — Address: 3329 a ILLINOIS

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): Cerebral HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): General Artesio - Sclerosis — 3 years 2

DUE TO (c): 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): No

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 Jan 2 · 1956, to April 26 · 1959 and last saw ~~her~~ him alive on April 26 · 1959
Death occurred at 6:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Julius Chas Roller M.D.

22b. ADDRESS: 2603 Cherokee St

22c. DATE SIGNED: 4·27·59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: APR. 29 1959

23c. NAME OF CEMETERY OR CREMATORY: S. S. PeTER & PAUL

23d. LOCATION (City, town, or county): ST. LOUIS (State) Mo

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: APR 28 '59

26. REGISTRAR'S SIGNATURE: Karl Smith. M.D.

(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.

CR 6-3636

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 Lamar C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

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.