

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003431

FILED VS JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 236** STATE FILE NUMBER

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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 | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 2400 S. 18th. St | | d. STREET ADDRESS (If outside, give location) 2400 S. 18th. St | |

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| 3. NAME OF DECEASED (Type or print) First NELLIE Middle Last GERHARDT | 4. DATE OF DEATH Month 1 Day 7 Year 1960 |
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|----------------------|-------------------------------|---|-----------------------------------|--------------------------------------|---|----------------|
| 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 7-28-1870 | 9. AGE (last birthday) 89 Yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|----------------------|-------------------------------|---|-----------------------------------|--------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Illinois | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME John Smith | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE |
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| 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 Sevilla Perich | Address 5050 Mattis Sc. Rd |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure - Pulmonary Edema | | INTERVAL BETWEEN ONSET AND DEATH 1.5 Hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerotic Heart Disease | 10 years |
| | DUE TO (c) Arteriosclerosis Generalized | unk. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200 | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) 4200 |
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| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ |
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|---|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **10-9-53** to **1-7-60** and last saw her alive on **1-7-60**
Death occurred at **11:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Henry J. Cooper M.D. | 22b. ADDRESS 818 Olive St. | 22c. DATE SIGNED 1/8/60 |
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|---|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 1-11-1960 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery | 23d. LOCATION (City, town, or county) (State) 7801 Gravois Ave Mo |
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| 24. FUNERAL DIRECTOR Riegerheim Bros | ADDRESS 6409 Gravois Ave | 25. DATE RECD. BY LOCAL REG. JAN 8 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Edmond H. Remelie*

Licensed Embalmer No. 4283

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.