

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 31 1960

=60-018174

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 150

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>6 yrs</b>		c. CITY OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR HOME <del>XXXX</del> <b>Stickler Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>608 N. Main St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Gehrke</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>XXXXXX</del> <del>XXXXXX</del>		8. DATE OF BIRTH <b>2/18/77</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Adair, Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>	
13a. FATHER'S NAME <b>Henry Gehrke</b>			13b. MOTHER'S MAIDEN NAME <b>Minerva Hart</b>			14. NAME OF HUSBAND OR WIFE <b>Bertha Gehrke</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-40-2170</b>		17. INFORMANT Address <b>Bertha Gehrke, Kirksville, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>							<b>5 years</b>	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
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.		Month, Day, Year						
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 <b>May-9-1960</b> to <b>May-22-1960</b> and last saw <del>him</del> <sup>her</sup> live on <b>May-22-1960</b>				Death occurred at <b>11:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Robert Stickler MD</i> (Degree or title)				22b. ADDRESS <b>Kirksville, Misspuri</b>			22c. DATE SIGNED <b>5-25-60</b>	
23a. BURIAL OR CREMATION, REMAINS (Specify)	23b. DATE	23c. NAME OF CEMETERY <del>XXXXXXXX</del> <b>Maple Hills</b>		23d. LOCATION (City, town, or county) <b>Kirksville, Adair, Mo.</b>		23e. (State)		
24. FUNERAL DIRECTOR <i>Walter Foster</i> ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>5-25-1960</b>		26. REGISTRAR'S SIGNATURE <i>Dora W. Ratliff</i>		

DOCUMENT  
MEDICAL CERTIFICATE OF ~~DR. STICKLER~~  
BY AFFIDAVIT OF

R. O. STRICKLER, M.D.

**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 *Nova E. Foster*  
**Nova E. Foster**

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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.