

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2232** STATE FILE NUMBER

FILED VS MAR 16 1961

DATE AMENDED

INSTEAD OF

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Kansas City	
Length of stay in 1b 5 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo. Hospital		d. STREET ADDRESS (If outside, give location) 18 W. 34th St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Henry George	Middle Gelzer	Last	4. DATE OF DEATH	Month March	Day 4	Year 1961
-------------------------------------	------------------------------	-------------------------	------	------------------	-----------------------	-----------------	---------------------

5. SEX Male	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 10/6/70	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---------------------------	------------------------	--------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	10b. KIND OF BUSINESS OR INDUSTRY Bank	11. BIRTHPLACE (City and state or country) Unknown 9	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Henry Gelzer	13b. MOTHER'S MAIDEN NAME Dorothea Schussler	14. NAME OF HUSBAND OR WIFE Elizabeth Gelzer
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT L.C. Robertson, Sup't.
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		10 Mon.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	Unknown
	DUE TO (c) Severe Hypertrophis & rheumatoid arthritis	30 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <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"/> No	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None
---	--	---

20c. TIME OF INJURY Hour None a.m. p.m.	Month, Day, Year None
--	---------------------------------

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.) None	20f. CITY, TOWN, OR LOCATION None	COUNTY	STATE
--	---	---	--------	-------

21. I attended the deceased from **December 1955** to **death** and last saw her/him alive on **3/4/61**
Death occurred at **3:50 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Harold E. Walters M.D.	22b. ADDRESS 3720 Washington St. hoi	22c. DATE SIGNED 3-5-61
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-5-61	23c. NAME OF CEMETERY OR CREMATORY Lexington, Mo.	23d. LOCATION (City, town, or county) Lexington, Mo.
---	----------------------------	---	--

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. MAR 6 1961	26. REGISTRAR'S SIGNATURE Earl Smith, 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elmer R. Sadwa

Licensed Embalmer No. 4077

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.