# SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=040175
STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1209

FILED DEC 4 1961

1. PLACE OF DEATH
a. COUNTY St. Joseph
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph
Length of stay in 1b: 19 Months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wyatt Park Rest Home 2705 Lafayette St.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN Easton
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First AUGUST Middle Last GERTEISEN

4. DATE OF DEATH: Month November Day 21, Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-19-1873
9. AGE (last birthday): 88
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (11) Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Farming
11. BIRTHPLACE (City and state or country): Boden, Germany
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Herman Gerteisen
13b. MOTHER'S MAIDEN NAME: Mary Beck
14. NAME OF HUSBAND OR WIFE: Ida Gerteisen

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.
17. INFORMANT: Mrs Alphonse Kneib Address: St. Joseph, Mo.

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): Arteriosclerosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 Previously & from 3/30/61 to 11/21/61 and last saw him alive on 10/23/61
Death occurred at 12:20a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Geo Redmond MD
22b. ADDRESS: St. Joseph, Mo.
22c. DATE SIGNED: 11/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov. 24, 1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Mo.

24. FUNERAL DIRECTOR: H.O. Sidenfaden & Son R.F.J. ADDRESS: St Joseph Mo
25. DATE RECD. BY LOCAL REG.: Nov. 24, 1961
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — DOCUMENT — DATE AMENDED

**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 Robert L Gayle

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.