

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013287

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3677** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 8 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST LOUIS</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>ST LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LITTLE SISTERS OF THE POOR</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <b>3400 S. GRAND</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK GERAU</b>						4. DATE OF DEATH Month Day Year <b>MARCH 29 1963</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 28 78</b>		9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ST LOUIS MO</b>		11. BIRTHPLACE (City and state or country) <b>ST LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>FREDERICK GERAU</b>				13b. MOTHER'S MAIDEN NAME <b>Louisa Hauck</b>				14. NAME OF HUSBAND OR WIFE <b>Louise Hueslman (Dece)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)						17. INFORMANT Address <b>233 FRED VOGELWEID 3795 MARIETTA FLORIDA</b>					
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Sen. Arteriosclerosis</b> DUE TO (c) <b>4200</b>										INTERVAL BETWEEN ONSET AND DEATH <b>yes</b> <b>yes</b>	
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"/> 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"/>		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 <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>Jan 1963</b> to <b>3/29/63</b> and last saw him alive on <b>3/23/63</b> . Death occurred at <b>Home</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>R. M. ...</b>						22b. ADDRESS <b>8059 Watson</b>			22c. DATE SIGNED <b>3/30/63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>APRIL 1 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem</b>				23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR <b>Geo Kurtis 2906 ...</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 30 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>					

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STATE OF TEXAS

**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 Eliuan Pounce

Licensed Embalmer No. 3403

P. O. Address 2906 Garretts

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.

*Dr. P. M. ...  
8059 ...  
after 3 pm - 8:00*