

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037562

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9585** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DATE AMENDED
Rev. 4/59		
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FILED OCT 4 1963	
1. PLACE OF DEATH a. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
c. CITY OR TOWN St. Louis	
d. STREET ADDRESS 3537 Oregon	
3. NAME OF DECEASED (Type or print) First Alma Middle Gerdes Last Gerdes	
4. DATE OF DEATH Month Sept. Day 24 Year 1963	
5. SEX Female	6. COLOR OR RACE White
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/29/05
9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME George Gaulbert	13b. MOTHER'S MAIDEN NAME Alma Mueller
14. NAME OF HUSBAND OR WIFE William Gerdes	
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 William Gerdes 3537 Oregon Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO (b) 200.1 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.	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 March 21, 1963 to Sept. 23, 1963 and last saw ^{her} him alive on Sept. 23, 1963 Death occurred at 5:35 am on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>George A. Rendleman</i> (Degree or title) George A. Rendleman, M.D.	22b. ADDRESS 812 Olive Street St. Louis 1, Mo.
22c. DATE SIGNED 9/25/63	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE 9/27/1963
23c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR <i>Thomas Kute</i> ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. SEP 25 1963
26. REGISTRAR'S SIGNATURE <i>W. D. Smith</i> 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

Eleanor Province

Licensed Embalmer No.

3403

P. O. Address

2906 Grass

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.