DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

791

REC'D NOV 13 1939

Registration District No. 1003

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33936

Primary Registration District No.

Registrar's No. 8474

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Faith Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

In this community Birth

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 8

(d) Street No. 7841 N. Broadway (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary Gevers 162

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William F. Gevers

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Sept. 14, 1870 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
69	0	17	hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business

MOTHER FATHER

12. Name Fred Woeckner

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Louisa Kahre

15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm F. Gevers

(b) Address 7841 N. Broadway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-39 (Month) (Day) (Year)

(c) Place: burial or cremation Friedens

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave.

19. (a) OCT 3 1939 (Date received local registrar) (b) [signature] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1st year 1939 hour 10:15 AM minute M.

21. I hereby certify that I attended the deceased from Sept 22, 1939, to Oct 1, 1939, that I last saw her alive on Oct 1, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Ruptured diverticulum of Sigmoid colon	5
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings: Of operation Ruptured Sigmoid Diverticulum

Of autopsy Fatty degeneration liver and heart.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence None

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. F. Miller (M. D. or other) 1

Address 8410 N Broadway St Louis Date signed 10/3/39 MD

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed William G. Buchho

Licensed Embalmer No. 2110

P. O. Address St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.