DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41709

Registration District No. JAN 12 1940 791

Primary Registration District No.

Registrar's No. 10832

1. PLACE OF DEATH: 1003

(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: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 535a Fassen St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Anton Gerhardt. 663

3. (b) If veteran, name war

3. (c) Social Security No. 489-12-9990

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Catherine Gerhardt

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

7. Birth date of deceased Sept. (Month) 24 (Day) 1886 (Year)

8. AGE: Years 53 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Hungary (City, town, or county) 7 (State or foreign country)

10. Usual occupation Violin maker

11. Industry or business Violin factory 3520 Olive

FATHER
12. Name Anton Gerhardt 7
13. Birthplace 7 Hungary (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Hungary (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rose Erdtman
(b) Address 535a Fassen St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter & Pauls

18. (a) Signature of funeral director Cullinane Bros
(b) Address 1710 N. Grand Blvd.

19. (a) DEC 19 1939 (Date received local registrar) (b) J. F. Budich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1939 hour 3 minute 30 p. M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Syphilis; Acute Nephritis; Cystitis; Fracture of left elbow; Inanition; suffered

Due to in fall from 2nd story window at his home 535a Fassen Street, on

Due to November 26th, 1939, at about 10:35 P.M. (WHETHER ACCIDENTAL OR SUICIDAL COULD NOT BE DETERMINED)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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 November 26th, 1939
(c) Where did injury occur? St. Louis, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Home (Specify type of place)
While at work? No (e) Means of injury 4

23. Signature Alfred Merry (M. D. or other)
Address Deputy Coroner Date signed 12.19.39

(Licensed Embalmer's Statement on Reverse Side)

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.

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. Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis MO

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.