No. 2
11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1941

Registration District No. 4099

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6079

Primary Registration District No. 1002

Registrar's No. 3851

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8
3
8

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 101 East 40th St., Apt. No. 201, 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 20 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 101 East 40th Street (If rural, give location) 0

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

3. (a) PRINT FULL NAME Roscoe F. GERLICHER.

3. (b) If veteran, name war World

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced 3

6. (b) Name of husband or wife Florence

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

7. Birth date of deceased Dec (Month) 7 (Day) 1888 (Year)

8. AGE: Years 52 Months 3 Days 19 If less than one day hr. min.

9. Birthplace Winona (City, town, or county) Minn (State or foreign country)

10. Usual occupation Salesman.

11. Industry or business Retail Drugs

FATHER
12. Name Herman F. Gerlicher
13. Birthplace (City, town, or county) Minn (State or foreign country)

MOTHER
14. Maiden name Sophia Staack
15. Birthplace Stanley (City, town, or county) Minn (State or foreign country)

16. (a) Informant Wm Gerlicher Brother

(b) Address Rochester Minn

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/28/41. (Month) (Day) (Year)

(c) Place: burial or cremation Winona, Minnesota.

18. (a) Signature of funeral director Mellody-McGilley

(b) Address K.C.Mo.

19. (a) 2/28/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-2 day 6-41 year hour minute 3:40 p M.

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

Immediate cause of death Cecile Cerebral Edema

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) X 3 A

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

(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 3

23. Signature Russell W. Dern (M. D. or other)

Address Farm Date signed

(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. 267 working under my personal supervision.

Signed .....

Licensed Embalmer No. 2795

P. O. Address KC

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

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