

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20465

State File No. _____

Registrar's No. **5277**

Registration District No. **791**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **BARNES HOSPITAL ()**
(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)

3. (a) PRINT FULL NAME **ELmer Benjamin Gaede**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **Unknown**

4. Sex **Male ()** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Elsie** 6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **Sept. 5 1890**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 9 20 hr. min.

9. Birthplace **Edward Co. Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Charlie Gaede**

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

14. Maiden name **Margaret Long**

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

16. (a) Informant **Mrs. Elsie Gaede**

(b) Address **Olney, Ill.**

17. (a) **Removal** (b) Date thereof **6/27/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Olney, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **JUN 26 1941** (b) **[Signature]**
(Date received at local health office) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **998**
(c) City or town **Olney**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural**
(If rural, give location)
(e) Citizen of foreign country? **2** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **June** day **6-25-41**
year **1941** hour _____ minute **5**³⁵ P.M.

21. I hereby certify that I attended the deceased from **6-13-41**
_____ 19____ to **6-25** 19**41**;
that I last saw him alive on **6-25** 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of left kidney with metastasis to ureters, lung, lymph nodes**
Due to _____

Due to _____
Other conditions (include pregnancy within 3 months of death) **5/2/41**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **[Signature]** (M. D. or dentist)
Address **BARNES HOSPITAL** Date signed **6-26-41**

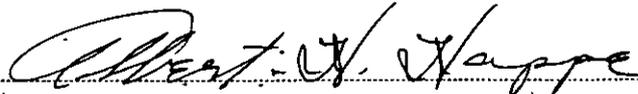
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 1861.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.