S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10838

Registration District No. 360 — Primary Registration District No. 6226 — Registrar's No. 53

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural Washington Tw
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs 6 m 25 days (Specify whether)
In this community 2 yrs 6 mo 25 days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Vernon
(c) City or town Rural Washington
(If outside city or town limits, write "RURAL")
(d) Street No. Township
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME ALBERT GAEDE
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Wid
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased 12 (Month) 25 (Day) 1855 (Year)

8. AGE: Years 89 ~~88~~ Months 3 Days ~~14~~ 17 — If less than one day ___ hr. ___ min.

9. Birthplace Germany (City, town, or county) ✓ (State or foreign country)
10. Usual occupation None
11. Industry or business ✓
FATHER
12. Name Wm Gaede
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Hoglan
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant Nicholas Gaede
(b) Address Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemet
18. (a) Signature of funeral director Fleming Home
(b) Address Nevada Mo
19. (a) 3-29-45 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3/28/45 day 28 year 1945 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from Oct 1943 to March 28, 1945 that I last saw him alive on March 27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Traumatic Shock	
Due to Fracture right hip (Femur)	15 days
Due to	
Other conditions Senile Psycosis (Include pregnancy within 3 months of death)	?
Major findings: Of operations ✓	
Of autopsy ?	

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) accident
(b) Date of occurrence 2 3
(c) Where did injury occur? State Hospital (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hospital (Specify type of place)
While at work? No (e) Means of injury Fall on floor
23. Signature R. G. Hall (M. D. or other) MD
Address Nevada Mo Date signed 3/28/45

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 3-45-254
Date Filed 4-5-45

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 me, Registered Apprentice No. , working under my personal supervision.

Signed L. B. Ferry
Licensed Embalmer No. 1768
P. O. Address Neoda Mo.

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.