. S. No. 2
0M—2-43
ev. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

24967

FILED JUL 16 1945

STANDARD CERTIFICATE OF DEATH

State File No. 8

Registration District No. 319 Primary Registration District No. 6076 Registrar's No. 1725

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
1517 Odgen Ave.,
(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:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 1517 Adgen Ave.,
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Peter Gereau.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Comeal Gereau

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Dec. 6, 1867.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	7	0	hr. min.

9. Birthplace Florissant, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business .....

FATHER
12. Name Frank Gereau
13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Octavie Marshall
15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Comeal Gereau
(b) Address 1517 Odgen Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10/45
(Month) (Day) (Year)
(c) Place: burial or cremation St. Ferdinand Cm.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave,

19. (a) 7-7-45 (Date received local registrar) (b) E. E. McGanan MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1945 hour 9.10 minute P.M. M.

21. I hereby certify that I attended the deceased from May 11, 1945 to July 7, 1945
that I last saw him alive on 7-6-, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of prostate	2 yr
Due to ?	
Due to 3	
Other conditions Senile changes (Include pregnancy within 3 months of death)	
Major findings: Of operations As above	
Of autopsy none made	

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 .....

23. Signature Joseph Davie (M. D. or other)
Address 406 Frisco Bldg Date signed 7-7-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Joseph Davie
Frisco Bldg.,
2/5 P¾M¾
GA. 1276.

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.....

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.