S. No. 2
M—2-43
. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr. Ruth

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 4 1945

State File No. 38374

Registration District No. 314 Primary Registration District No. 6064 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair

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

(c) Name of hospital or institution: / Osceola Hosp

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)

In this community 27 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Clair

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Samuel William Gerster

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Sarah Belle Gerster

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased June (Month) 20 (Day) 1854 (Year)

8. AGE: Years 91 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Fairfield Co. (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER

12. Name Johannes Gerster

13. Birthplace Bern (City, town, or county) Switzerland (State or foreign country)

14. Maiden name Elizabeth Gass

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

16. (a) Informant Mrs Sarah Belle Gerster

(b) Address Osceola, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-1945 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Pleasant Mound Cemetery

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola, Mo.

19. (a) 11-1-1945 (Date received local registrar) (b) Ruth Seeers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17 year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 1945, to Oct 17 1945, that I last saw him alive on Oct 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Endocarditis	2 mo
Due to Influenza	
Due to	
Other conditions (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)

(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 Ruth Seeers (M. D. or other)

Address Osceola Mo Date signed 11-1-45

1507 (Licensed Embalmer's Statement on Reverse Side)

11-45--1144
12-3-45

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3038

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.