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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

State File No. **39185**

# FILED DEC 21 1945 STANDARD CERTIFICATE OF DEATH 1003

Registrar's No. **10687**

Registration District No. **218**

Primary Registration District No. \_\_\_\_\_

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:  
Deaconess 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 6109 Garesche Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Gerken

### MEDICAL CERTIFICATION

3. (b) If veteran, name war No.

20. DATE OF DEATH: Month Dec. day 9th  
year 1945 hour 8 minute -- A.M.

4. Sex Male 5. Color or race White

21. I hereby certify that I attended the deceased from 11/27/45, 19\_\_\_\_, to 12/9/45, 19\_\_\_\_;

6. (b) Name of husband or wife Charles H. Gerken, Dec'd 1/7/06

that I last saw her alive on 12/8/45, 19\_\_\_\_; and that death occurred on the date and hour stated above.

7. Birth date of deceased: Mar. 6, 1863  
(Month) (Day) (Year)

Immediate cause of death:  
Chronic myocarditis  
Myocardial Failure

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>9</u>	<u>3</u>	hr. _____ min. _____

Due to Arteriosclerosis

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

Due to Fractured left shoulder

10. Usual occupation Not employed

Other conditions:  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

12. Name James Morgan

Of autopsy No autopsy

13. Birthplace Copenhagen, Denmark  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

14. Maiden name Magdeline Fischer  
(City, town, or county) (State or foreign country)

16. (a) Informant H. Morgan Gerken  
(b) Address 6109 Garesche Ave.

22. If death was due to external causes, fill in the following:

17. (a) Cremation (b) Date thereof 12/11/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (Specify) \_\_\_\_\_

(c) Place: burial or cremation Valhalla Crematory

(b) Date of occurrence 11/27/45

18. (a) Signature of funeral director Robert J. Ambruster  
(b) Address Clayton Rd. at Concordia Lane

(c) Where did injury occur? fell in home  
(City or town) (County) (State)

19. (a) DEC 10 1945 (b) J. F. Bredsch  
(Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
in home  
(Specify type of place)

23. Signature Dr. W. W. Montoye (M. D. or R.N.)  
Address Missouri Theater Bldg. Date signed 12/9/45

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

MOTHER FATHER

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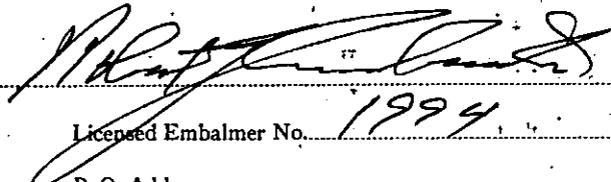
**STATEMENT BY LICENSED EMBALMER**

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. ....

1994

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.**