

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

343

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. 20 days
(Specify whether years, months or days)
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Agency, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Agency Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John Gerken

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Unknown
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business Unknown

MOTHER FATHER
12. Name John Gerken
13. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Angelina
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant St. Joseph's Hospital
(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 3/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Agency Mo. Cemetery

18. (a) Signature of funeral director Heaton - Brown
(b) Address St. Joseph, Mo.

19. (a) 3-13-47 (b) L. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1947 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from January 10 1947 to March 2, 1947
that I last saw him alive on March 2, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 wks

Other Conditions: Emaciation 2 yrs.
Hypertrophy of Prostate no. of yrs.

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations ✓ Of autopsy ✓
PHYSICIAN 137P
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) (c) Means of injury

23. Signature Quinn Stary MD (M. D. or other) _____
Address 405 1/2th Blvd Date signed 3-3-47
St. Joseph, Mo.

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

Call 3-13-47
back

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 Eugene Wood
Licensed Embalmer No. 5804
P. O. Address 319 So 10th St. Joseph, 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.