

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

20875
State File No. 5557
Registrar's No. _____

FILED JUN 28 1948
Registration District No. 398

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(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)

3. (a) PRINT FULL NAME

EDWARD A GERST

3. (b) If veteran, name war _____

3. (c) Social Security No. 498-26-7057

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frances 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased February 25, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 3 24 hr. min.

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

10. Usual occupation Stock Clerk

11. Industry or business Famous-Barr Co.

12. Name Edward Gerst

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Anne Mueller

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Frances Gerst

(b) Address 5889 Theodosia Ave.

17. (a) Burial (b) Date thereof 6-21-48
(Burial, cremation, or removal) (Month, Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1775 Union Road

19. (a) JUN 20 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. 5889 Theodosia Ave.
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19th
year 1948 hour 3 minute 05 A. M.

21. I hereby certify that I attended the deceased from 4/26/48
_____ 19____ to June 19th 19 48
that I last saw him alive on June 19th 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration _____

Due to Arteriosclerotic Heart Disease

Due to _____

Other conditions Benign Hypertrophy Prostate
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____ (Specify type of place)
(Specify type of place) _____
(Specify type of place) _____

23. Signature [Signature] (M.D. or other) _____
Address 1515 Lafayette Date signed 6/19/48

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

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17
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MOTHER FATHER

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.....

R. W. Wilkinson

Licensed Embalmer No. *3575*

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.