

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 10949
 Registrar's No. 10949

Registration District No. 318 Primary Registration District No. 1005

1. PLACE OF DEATH: 318

(a) County: St. Louis, Missouri.

(b) City or town: St. Louis, Missouri.
(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: 1 WEEK
(Specify whether years, months or days)

In this community: _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1005

(a) State: Mo (b) County: 017

(c) City or town: ST LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No.: 3558 CRITTENDEN ST.
 Memorial
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country: _____

3. (a) PRINT FULL NAME: MAX W. GERTH

3. (b) If veteran, name war: BOKER REBELLION-NAVY

3. (c) Social Security No.: 488-32-3211

4. Sex: MALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: SINGLE

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: MAY 1 1869
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 16
 If less than one day: _____ hr. _____ min.

9. Birthplace: PITUA, PENN
(City, town, or county) (State or foreign country)

10. Usual occupation: RETIRED PAINTER

11. Industry or business: OWN

12. Name: UNKNOWN

13. Birthplace: UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name: UNKNOWN
(City, town, or county) (State or foreign country)

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

16. (a) Informant: MRS MAE KOERNER

(b) Address: 3558 CRITTENDEN ST.

17. (a) BURIAL (b) Date thereof: DEC 20-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: LAUREL PARK CEM.

18. (a) Signature of funeral director: Wm J. Robert J. H. Co

(b) Address: 1905 S Grand Blvd.

19. (a) DEC 19 1948 (b) J. H. Lauer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17th
 year 1948 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from 12/11/48
 _____, 19____, to Dec. 17th, 19 48

that I last saw him alive on Dec. 17th, 19 48
 and that death occurred on the date and hour stated above.

Immediate cause of death: *Crimina of the colon*

Duration: _____

Due to: *Hb*

Due to: _____

Other conditions: *of pneumonia*
(Include pregnancy within 6 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? _____

While at work? _____ (Specify type of place)

(c) Means of injury: _____

23. Signature: J. H. Lauer 1515 Lafayette 10/18/48
 Address: _____ Date signed: _____

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

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 *J. Allen Davis Jr*
Licensed Embalmer No. *4063*
P. O. Address *St Louis, 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.