No. 300
10-48

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14079
3498

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1500 East Grand Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1500 E. Grand Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Gerhard b. (Middle) R. c. (Last) Recker

4. DATE OF DEATH (Month) April (Day) 16. (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 2. 1865
9. AGE (In years last birthday): 84 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Machinist
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Mary Ellen Recker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Paul Harbaugh, **ADDRESS**: 1500 E. Grand Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Myocarditis

DUE TO (c) 93

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 422

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1948, *to* Apr. 16, 1949, *that I last saw the deceased alive on* Apr. 16, 1949, *and that death occurred at* 1:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. A. Uhlemeyer
23b. ADDRESS: 4362 Warne Av.
23c. DATE SIGNED: 4/18/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: April 19, 49
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cem
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: APR 18 1949
REGISTRAR'S SIGNATURE: J. R. Sarster
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: W. A. Stock 2117 E. Grand.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed [illegible]

Signed.....
Student Embalmer

Licensed Embalmer No. 3041

P. O. Address 2117 E. [illegible]

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.