

5. No. 300
v. 10-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
10/26/53
7602 S. B. Bway
10/26/53
10/26/53

FILED OCT 5 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32227

BIRTH NO. _____ REG. DIST. NO. 162 PRIMARY REG. DIST. NO. 5595 Registrar's No. 80

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jefferson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Purdopolis Rock | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249 | |
| c. LENGTH OF STAY (In this place) _____ | | d. STREET ADDRESS (If rural, give location) 3015 Iowa Ave 1 | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Four Oaks Nursing Home | | | |

| | |
|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Reinhold c. (Last) Gerecke | 4. DATE OF DEATH (Month) (Day) (Year) 9-20-1953 |
|--|---|

| | | | | | | |
|--------------------|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH 12-8-1869 | 9. AGE (In years) (last birthday) 83 | 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) Metal Polisher | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and State or Foreign Country) Germany | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|--|---|--|

| | | |
|--|--|-----------------------------------|
| 13a. FATHER'S NAME August Gerecke | 13b. MOTHER'S MAIDEN NAME Friede Schaefer | 14. NAME OF HUSBAND OR WIFE _____ |
|--|--|-----------------------------------|

| | | | |
|--|--|--|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 491-16-4122 | 17. INFORMANT'S SIGNATURE OR NAME Arthur R. Bried | ADDRESS 15 Iowa 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerotic Heart Disease DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. | | 4200 | |

| | | |
|------------------------------|--|---|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION Dr. Clarence Miller attended Patient | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------------|--|---|

| | | |
|---|--|---|
| 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) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on **20 Dec, 1953** and that death occurred at **10:30 a.m.** from the causes and on the date stated above.

| | | |
|---|----------------------------------|------------------------|
| 23a. SIGNATURE John G. Kellitt (Degree or title) _____ | 23b. ADDRESS 7002 S. Bway | 23c. DATE SIGNED _____ |
|---|----------------------------------|------------------------|

| | | | |
|--|----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 9-24-1953 | 24c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard | 24d. LOCATION (City, town, or county) (State) 7600 Rock Hill Road Mo |
|--|----------------------------|---|---|

| | | | |
|--|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. Sept 26 53 | REGISTRAR'S SIGNATURE Paith J. J... | 25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhain | ADDRESS 6409 Gravois Ave |
|--|--|--|---------------------------------|

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

OCT 5 1952

DATE RECEIVED SEP 28 1953

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.

Student
Student Embalmer

Signed Jan M. Leman

Licensed Embalmer No. 4343

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.