

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24563
State File No. 7068

318

1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		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 town OR TOWN ST LOUIS,		c. LENGTH OF STAY (in this place) c. CITY OR TOWN ST LOUIS,	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2027 EAST DE SOTO AVE		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) H. c. (Last) GERWITZ		4. DATE OF DEATH (Month) (Day) (Year) JULY 29, 1954	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH April 24, 1876
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME BERNARD DIETERMAN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE WILLIAM A. GERWITZ		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME THOMAS GERWITZ 2027 E. DE SOTO 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Cardiac decompensation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>AS CV disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4221		22. I hereby certify that I attended the deceased from <u>Jan. 6, 1951</u> , to <u>July 29, 1954</u> , that I last saw the deceased alive on <u>July 29, 1954</u> , and that death occurred at <u>7:25 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>H. Appenheimer, M.D.</u> (Degree or title)		23b. ADDRESS <u>508 N. Grand Blvd., St. Louis 33</u>	
23c. DATE SIGNED <u>July 30, '54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE <u>8/2/54</u>		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
24d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>St. Carl Smith M.D.</u> STROOT - CARROLL 4600 NATURAL BRIDGE AVE	

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. .

Student.....
Signature of Student Embalmer

Signed *M. W. Rueter*

Licensed Embalmer No. *4865*

P. O. Address *St Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.