

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31813**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7780**

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 township) OR TOWN 915 N. Grand, St. Louis, Mo		c. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place) 5 Days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		e. STREET ADDRESS (If rural, give location) 14 6425 MURDOCK	
3. NAME OF DECEASED (Type or Print) a. (First) HERMAN b. (Middle) F. J. c. (Last) GERKE		4. DATE OF DEATH (Month) (Day) (Year) 8 22 54	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-11-92
9. AGE (In years last birthday) 62	10. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Hours	10. IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and State or Foreign Country) MOUNT OLIVE, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME FRED GERKE	
13b. MOTHER'S MAIDEN NAME LYDIA SWING		14. NAME OF HUSBAND OR WIFE Bertha Gerke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY # 490-32-0308 <i>Unknown</i>	
17. INFORMANT'S SIGNATURE OR NAME VA HOSP. RECORDS, ST. LOUIS, MO.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PARALYTIC ILEUS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) SECONDARY TO CHOLECYSTECTOMY DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY CONGESTION. PULMONARY EMBOLUS SMALL LOWER LOBE		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 4 DAYS 3 DAYS	
19a. DATE OF OPERATION 8-18-54	19b. MAJOR FINDINGS OF OPERATION ACUTE CHOLECYSTITIS AND EMPYEMA		20. AUTOPSY? YES <input checked="" 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) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 585X	
22. I hereby certify that I attended the deceased from 8-17-54 , 19____, to 8-22-54 , 19____, that I last saw the deceased on 8-22-54 , and that death occurred at 11:15A m., from the causes and on the date stated above.			
23a. SIGNATURE R. W. Minnihan (Degree or title) R. W. MINNIHAN M.D.		23b. ADDRESS VAH, ST. LOUIS, MO.	23c. DATE SIGNED 8-22-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug. 25, 1954	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
DATE REC'D BY LOCAL REG. AUG 23 1954	REGISTRAR'S SIGNATURE J. Earl Smith, m.d.	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister Colonial Mortuary, Chippewa ADDRESS 6464	

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 *Levin C. Hoffner*.....

Licensed Embalmer No. *3877*
P. O. Address *7814 S.B.*

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.