

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018370  
STATE FILE NUMBER

FILED MAY 29 1959 Registration District No. 187 Primary Registration District No. 3048 Registrar's No. 142

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Livingston</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>               |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Chillicothe</b>  |                                  | c. CITY OR TOWN <b>Chillicothe</b>  |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>City hospital</b>  |                                  | Length of stay in lb <b>11 yrs.</b>   |  |
| d. STREET ADDRESS <b>504 Ryan Lane</b>   |                                  | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED First Middle Last<br><b>ELIZABETH GERHARDT</b>   |                                  |   | 4. DATE OF DEATH Month Day Year<br><b>May 20, 1959</b>               |
| 5. SEX<br><b>Fem.</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 24, 1885</b>                             |
| 9. AGE (In years last birthday) <b>74</b>  |                                  | 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)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Austria Hungary</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  | 13a. FATHER'S NAME<br><b>Peter Schmidt</b>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Christina Hartmen</b>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>John Gerhardt</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT Address<br><b>Mr. John Gerhardt, Chillicothe, Mo.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia Terminal</b><br>DUE TO (b) <b>Carcinoma of Colon</b><br>DUE TO (c) <b>1538</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Operation for Carcinoma of Colon - Nov. 1 - 58</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>9 mts</b>     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                  | 20c. TIME OF INJURY Hour Month, Day, Year<br>a.m. p.m.  |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 20f. CITY, TOWN, OR LOCATION   |                                  | COUNTY STATE  |  |
| 21. I attended the deceased from <b>Nov. 15 - 58</b> to <b>May 20 - 59</b> and last saw her alive on <b>May 19 - 59</b><br>Death occurred at <b>6:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Joseph A. Conrad, M.D.</b>  |                                  | 22b. ADDRESS<br><b>Chillicothe, Mo</b>  |  |
| 22c. DATE SIGNED<br><b>May 22 - 59</b>   |                                  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |
| 23b. DATE<br><b>May 22, 1959</b>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  |
| 23d. LOCATION (City, town, or county)<br><b>St. Joseph, Mo.</b>  |                                  | 24. FUNERAL DIRECTOR ADDRESS<br><b>Donald Gordon, Chillicothe, Mo.</b>  |  |
| 25. DATE RECD. BY LOCAL REG.<br><b>5/22/59</b>   |                                  | 26. REGISTRAR'S SIGNATURE<br><b>Francis B. Nail</b>   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

DEC 5 1982

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 *Arnold Jordan* .....

Licensed Embalmer No. *4191* .....  
P. O. Address *Chillicothe 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.