

REC'D JUN 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16461
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... 791
(b) Township..... Primary Registration District No..... 1003
(c) City..... St. Louis, Mo. (d) Street No..... City Infirmary St.
(e) Length of residence in city or town where death occurred 53 yrs. 4 mos. 15 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

656 William Bernhard
(a) Residence, No. 5800 Arsenal St. 13 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 15, 1885		
7. AGE	YEARS 53	MONTHS 4
	DAYS 13	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	Baker
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)		
FATHER	13. NAME	Peter Bernhard
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Unknown
MOTHER	15. MAIDEN NAME	Elizabeth Schaefer
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Unknown

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from August 11, 1938, to April 28, 1939

I last saw him alive on April 28, 1939 Death is said to have occurred on the date stated above, at 6:40 P.M.
The principal cause of death and related causes of importance were as follows:

Myocardial Insufficiency
Date of onset

Other contributory causes of importance:
*Supertensive Heart Disease
Cardiac Decompensation
Cardio-Renal-Vascular Disease*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) *R. Potashnick*, M. D.
(Address) *Evolution*

17. INFORMANT J.G. Sullivan (ADDRESS) 5800 Arsenal St.
18. BURIAL, CREMATION, OR REMOVAL PLACE *St Paul Church* 5/1 1939
19. FUNERAL DIRECTOR (NAME) *J. H. Beck* (ADDRESS) *2842 Meramec St*
20. FILED *MAY 1 1939* *J. D. Budek* Local Registrar

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X16603

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.