

Registration District No. **791 1**

Primary Registration District No. **1003**

Registrar's No. **9133**

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4930 Robert
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **life**
years, months or days)

8. (a) PRINT FULL NAME **Bertha Gutwald**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **Robert** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec 12 1871**
(Month) (Day) (Year)

8. AGE: **68** Years **10** Months **22** Days
 If less than one day hr. _____ min. _____

9. Birthplace **St. Louis** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home** **6**

11. Industry or business _____ **6**

12. Name **Joseph Frommenroch** **6**

13. Birthplace **Not known** **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Not known** **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Adèle Neppi**

(b) Address **4930 Robert**

17. (a) **burial** (b) Date thereof **11/7/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belleville, Ill.**

18. (a) Signature of funeral director **Just Zegerheim**

(b) Address **7027 Gravois**

19. (a) **NOV 6 1940** (b) **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis** **2**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4930 Robert**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** Day **4th**
 year **1940** hour **1** minute **-** P. M.

21. I hereby certify that I attended the deceased from **April 7th,** 19 **40** to **Death**, 19 **40**;
 that I last saw **her** alive on **November 4th,** 19 **40**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Endo Carditis** **2 Mo.**
caused by ch. endocarditis

Due to _____

Due to _____

Other conditions **Chronic Arteriosclerosis**
(Include pregnancy within 3 months of death) **1 year**

Major findings: Of operations **92a**

Of autopsy **No**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **XXXX**
 (b) Date of occurrence **XXXX**
 (c) Where did injury occur? **XXX**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
XXXX

While at work **XX** (Specify type of place)
(a) Means of injury

23. Signature **Dr. H. H. Haller** (M. D. or D.D.S.)
 Address **3608 So. Grand Blvd.** Date signed **11/5/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.