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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3734**

FILED MAY 2 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

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: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No. 1137 Terrace Drive
(If rural, give location)

(e) Citizen of foreign country? 1
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Bertha Gerlitz Menze

3. (b) If veteran, name war No. _____ 3. (c) Social Security No. None.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles Theodore Menze 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 14, 1878
(Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business Housewife

MOTHER FATHER

12. Name ? Gerlitz

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. L. Flegle

(b) Address 11 Fair Oaks

17. (a) Burial (b) Date thereof 4/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Concordia Rd. at Concordia Lane

19. (a) _____ (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1944 hour 11 minute _____ A. M.

21. I hereby certify that I attended the deceased from April ?, 1944, to April 20, 1944
that I last saw her alive on April 20, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis

Due to _____
Due to _____

Other conditions Myocarditis, Chronic
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. P. Pernoud (M. D. of State) _____
Address 3115 S. Grand Blvd. Date signed 4/21/44

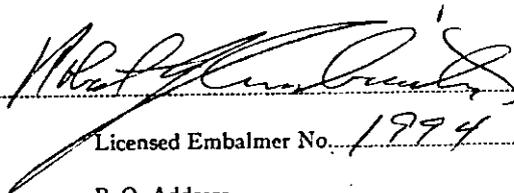
STATEMENT BY LICENSED EMBALMER

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. 1994

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, fact should be so stated above.