

#58338

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21532

FILED JUN 18 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4958

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
 (b) City or town St. Louis, Missouri.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff
 (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

3. (a) PRINT FULL NAME ANNA BERTEL3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. See F 1 5. Color or race W 6. (a) Single, widowed, married, divorced M!
 6. (b) Name of husband or wife Anthony Bertel 6. (c) Age of husband or wife if alive 90 years
 7. Birth date of deceased July 24 1868
 (Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 8 If less than one day hr. _____ min. _____9. Birthplace St. Louis Missouri (City, town, or county) (State or foreign country)10. Usual occupation at home

11. Industry or business _____

12. Name Fred Walker13. Birthplace U.S.A. (City, town, or county) (State or foreign country)14. Maiden name Mary Wendel15. Birthplace USA (City, town, or county) (State or foreign country)16. (a) Informant Frances Belt(b) Address 4027 Pennsylvania17. (a) _____ (b) Date thereof 6/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Peter's Paul18. (a) Signature of funeral director Wagnermuller F.H.(b) Address 3819 S Grand19. (a) JUN 3 1946 (b) J. F. Brudack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 086
 (c) City or town St. Louis Missouri 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3435 Memorial (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd
year 1946 hour 9:30 minute A M.21. I hereby certify that I attended the deceased from 5/28/46
19____, to 6/2/46 19____;
that I last saw h. DEF alive on 6/2/46 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Lymphosarcoma Duration 1
Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 023. Signature W. W. F. H. G. H. G. H. Date signed 6/9/46 (other) _____

Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE LEGIBLY—USE 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Elms R Cadwell*

Licensed Embalmer No. *4077*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 49680

Registration District No. 318

Primary Registration District No. 1003

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:

(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)

3. (a) PRINT FULL NAME

Auna Bertel

3. (b) If veteran,
name war.....

3. (c) Social Security
No.....

4. Sex F

5. Color or
race W

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

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
alive.....

7. Birth date of deceased July 24 1866
(Month) (Day) (Year)

8. AGE: Years Months Days

If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
to..... 19.....
that I last saw him.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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..... (M. D. or other).....
Date signed.....

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

SUPPLEMENTARY

Additional
Supplementary
Information
Requested

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

20401

21532