

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **1099**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
 (b) City or town ST. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Alexian Brothers Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 month - 10 days
 (Specify whether
 In this community 2 years
 years, months or days)
(Thomas F. Hurley)

3. (a) PRINT FULL NAME Brother Harold Bertram

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced SO
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 3rd., 1928
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 1 28 hr. _____ min.

9. Birthplace St. Paul Minn.
 (City, town, or county) (State or foreign country)

10. Usual occupation Religious

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Hurley
 13. Birthplace Ireland 4
 (City, town, or county) (State or foreign country)
 14. Maiden name Theresa Jagoe
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Brother Henry Edmund
 (b) Address La Salle Institute

17. (a) Removal (b) Date thereof 2-1-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul, Minn.
 18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd.

19. (a) FEB 3 1948 (b) J. J. Brennan
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96
 (c) City or town Glencoe 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. LaSalle Institute 3
N. R. (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 1
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day FIRST
 year 1948 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12-22-47
 _____, 19____, to 1/31/48, 19____
 that I last saw him alive on 1/31/48, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Gut mucus hemorrhage
 Due to Tuberculosis (Pul)
with Cavitation
 Due to _____
 Other conditions None
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
 Of operations _____
 Of autopsy Same
 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) (2) Means of injury (1)
 23. Signature Ed Hoffman (M. D. or other) _____
 Address 4065 St. Grand Date signed 2/1/48

1299

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

JOSEPH L. FERRIS, M. D.
A. DAVID HOFFMANN, M. D.
4065 SOUTH GRAND BLVD.
ST. LOUIS 18, MO.

March 1, 1948

10901
J. Earl Smith, M.D.
Medical Director
Com. Dis. Control Section

Dear Sir,

In regard to the case of Bro.
Harold Bertz, who expired on
2-1-48. The clinical diagnosis
and the provisional anatomical
diagnosis at autopsy was tuberculous
pneumonia. However, a recent
report on the microscopic sections
reveals that there is no evidence of
tuberculosis and the final diagnosis
is periarteritis nodosa. Because
the death certificate could not be
delayed & the clinical & gross
diagnoses were tuberculous
pneumonia, the death certificate

I hope this information will
be of value to you in straightening
out the records. If I can be of any
service I shall be glad to cooperate

Respectfully

Art Hoffmann W.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **1099**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis city
(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)

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 _____

3. (a) PRINT FULL NAME **REV. HAROLD BERTZAM**

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____ (State or foreign country) _____
15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 3/4/48 (b) J. J. Prendergast
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month FEBRUARY day 1st
year 1948 hour _____ minute _____ M.

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

PERIARTERITIS NODOSA

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____
99

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

Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
MAR 5 1948

