

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Deaconess 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 St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2709 January Ave.  
13 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MABEL C. BERGHOLTZ

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

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased Nov. 17 1897  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
50 8 4 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name John Barlow

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

14. Maiden name Mary Casey

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

16. (a) Informant James Bergholtz  
(b) Address 2709 January Ave.

17. (a) Burial (b) Date thereof 7-24-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Und. Co.  
(b) Address 4228 So. Kingshighway Bl.

19. (a) JUL 22 1948 (b) J. F. Breda  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21  
year 1948 hour 3:03 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from 27 July 1948 to 21 July 1948  
that I last saw him alive on 28 July 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Portal cirrhosis Duration 6 mos

Due to Chronic hepatitis

Due to Chronic hepatitis

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Portal cirrhosis

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) \_\_\_\_\_ (Specify type of injury) \_\_\_\_\_

23. Signature John W. May (M. D. or other) MD.

Address 5930 South St. Date signed 22 July 48

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 *Edwin A. Mc Dermott*

Licensed Embalmer No. *3024*

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.**