

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42808
Registrar's No. 2914

Registration District No. 21

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mt. St. Rose Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Three Wks.
(Specify whether
In this community Life Time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 1 Box 388 Robertson Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bernice Foersterling

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 Married
6. (b) Name of husband or wife Melvin Foersterling
6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased April 20, 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 7 27 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Floyd Mulherin
13. Birthplace Ellsbury Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Laura Watson
15. Birthplace Ellsbury Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Melvin Foersterling
(b) Address Rt. 1 Box 388 Robertson Mo.

17. (a) Burial (b) Date thereof 12/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Lebanon Cemetery
Colliers Funeral Home

18. (a) Signature of funeral director _____
(b) Address 10123 St. Charles Rd.

19. (a) 12-24-48 (b) Shirley L. Lunge
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17,
year 1948 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from
September 3, 1948, to December 17, 1948.
that I last saw her alive on December 14, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardio respiratory failure
Due to Pulmonary tuberculosis
Due to 13 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 _____
Signature Shirley L. Lunge (M. D. or other) _____
Address 3903 Olive Date signed 12/19/48

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

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

10123 St. Charles

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.