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FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 31601
8357 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri	
c. LENGTH OF STAY (in this place) 45 yrs.		d. STREET ADDRESS (If rural, give location) 6045 Westminster	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6045 Westminster			

3. NAME OF DECEASED (Type or Print) a. (First) Rose b. (Middle) c. (Last) Berger			4. DATE OF DEATH (Month) (Day) (Year) 9 28 1949		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) Ab. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia 6	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown Frank		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Max Berger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Al Berger		ADDRESS 734 Syracuse			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterial Thrombosis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis, General DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 332X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H-500	

22. I hereby certify that I attended the deceased from June 3, 1949, to Sept. 28, 1949, that I last saw the deceased alive on Sept 29, 1949, and that death occurred at 5A m., from the causes and on the date stated above.

23a. SIGNATURE Harrison M. Meyer M.D.		23b. ADDRESS 508 N. Grace		23c. DATE SIGNED 9/28/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/29/1949		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	
24d. LOCATION (City, town, or county) (State) University City, Mo.					

25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial 4715 McPherson Ave.		ADDRESS			
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed *Quinn J. Padung*

Licensed Embalmer No. 4559

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.