

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7878**

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Galveston | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) 2nd & Broadway | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital | | d. STREET ADDRESS (If rural, give location) NR. | |

| | | | | | |
|---|----------------------------------|--|---------------------------------------|---|---------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) Willie | b. (Middle) Shaw | c. (Last) Bertram | Sept. 10 1949 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR |
| | | Widowed | Jan. 17, 1877 | 72 | 7 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Housewife | | XXXX | | Galveston, Tex. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |

| | | | | | |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Frederick Bertram Dad. | |
| 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 ADDRESS Edward B. Banks 8914-Sycamore Court Overland | |

| | | | | | |
|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | Cardiac failure | | 3 hrs | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | DUPLICATE TO (b) Arterio Sclerotic heart disease | | | |
| DUPLICATE TO (c) | | | | | |

| | | | | | |
|------------------------|--|----------------------------------|--|--|--|
| 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) 932 | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 11210 | |

22. I hereby certify that I attended the deceased from **Sept. 4, 1949** to **Sept. 10, 1949**, that I last saw the deceased alive on **Sept. 9, 1949**, and that death occurred at **6A** m., from the causes and on the date stated above.

| | | | | | |
|--|--|--|--|--|--|
| 23a. SIGNATURE (Degree or title) Wm. B. Lester | | 23b. ADDRESS 4652 Maryland | | 23c. DATE SIGNED 9-12-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 9-13-49 | | 24c. NAME OF CEMETERY OR CREMATORY via American Airlines | |
| 24d. LOCATION (City, town, or county) (State) to Galveston, Tex. | | 25. FUNERAL DIRECTOR'S SIGNATURE Baumann Bros. | | ADDRESS 2504 Woodson Rd. Overland, Mo. | |
| DATE REC'D BY LOCAL REG. SEP 12 1949 | | REGISTRAR'S SIGNATURE W. B. Lester | | | |

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 3454

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed David C. Johnson

Licensed Embalmer No. 3454

P. O. Address Overland 147

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.