

FILED MAY 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11469
3943
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 township) OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2169

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital

d. STREET ADDRESS (If rural, give location) 16 3139 Arsenal St.

3. NAME OF DECEASED a. (First) Barbara b. (Middle) Chippewa c. (Last) Mersinger

4. DATE OF DEATH (Month) (Day) (Year) April 24, 1951

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH January 21, 1959

9. AGE (In years last birthday) 92 3 3 3 3 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Troy, ILL.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Schwend

13b. MOTHER'S MAIDEN NAME Maria Denler

14. NAME OF HUSBAND OR WIFE John Mersinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS William J. Mersinger 3139 Arsenal St.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH 10 days
ANTECEDENT CAUSES Senile Arteriosclerosis 10 yr
DUE TO (b) _____
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

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from 10-14, 1947, to 4/24/51, 1951, that I last saw the deceased alive on 4/24, 1951, and that death occurred at 11:45A m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____

23b. ADDRESS 5600 S Compton

23c. DATE SIGNED 4/26/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 4/27/51

24c. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cemetery Blackjack,

24d. LOCATION (City, town, or county) (State) Illinois

DATE REC'D BY LOCAL REG. APR 26 1951

REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert F. Gibson

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.