

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 39846
10729

FILED DEC 15 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____ Registrar's No. 10729

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis 20 69	
c. LENGTH OF STAY (in this place) 3 weeks		d. STREET ADDRESS (If rural, give location) 5334 Greer Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) A. c. (Last) Unland			4. DATE OF DEATH (Month) (Day) (Year) Dec. 2 1951		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 28 1879	9. AGE (in years last birthday) 72	10. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	

13a. FATHER'S NAME Carl Heinrichs	13b. MOTHER'S MAIDEN NAME Frieda Mayrose	14. NAME OF HUSBAND OR WIFE Harry H. Unland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harry H. Unland, 5334 Greer Ave.

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis Hypertension		
	3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. uremia		

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)
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? 331X

22. I hereby certify that I attended the deceased from 10-24, 1951, to 10-2, 1951, that I last saw the deceased alive on 10-23, 1951, and that death occurred at 1 a. m., from the causes and on the date stated above.

23a. SIGNATURE Irvn J. Berwald M.D. (Degree or title)	23b. ADDRESS 3409 N. Union	23c. DATE SIGNED 12-3-51
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12/5/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		

DATE REC'D BY LOCAL REG. DEC 3 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral, 1905 Union Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Irwin I. Berwald,
3409 Union Blvd.

(1 - 5)

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 R. Thompson

Licensed Embalmer No. *45-137*

P. O. Address *St. Louis*

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.