

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 22 1952

BIRTH NO. 18240 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1856

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>75501, Louisiana</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Booth Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>15 St. Louis 2159</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Joseph</u> c. (Last) <u>Rellergert</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26, 1952</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>Feb 26, 1952</u>
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) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY?		<u>U</u>	

13a. FATHER'S NAME <u>Aloysius Carl Rellergert</u>	13b. MOTHER'S MAIDEN NAME <u>Ludmilla M. Wibbenmeyer</u>	14. NAME OF HUSBAND OR WIFE
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 <u>Aloysius C. Rellergert</u> ADDRESS <u>5501 Louisiana</u>

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Precipitated labor, no respiratory response.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>60 minutes</u>
	ANTECEDENT CAUSES MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>7610</u>	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 26, 1952 to _____, 19____, that I last saw the deceased alive on 2-26, 1952, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Leroy E. Ellison M.D.</u> (Degree or title)	23b. ADDRESS <u>3616 S Broadway, St Louis, Mo.</u>	23c. DATE SIGNED <u>Feb 26, 1952</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>2-27-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Perryville, Mo.</u>
24d. LOCATION (City, town, or county) (State)	<u>Perryville, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>FEB 27 1952</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bey Funeral Home, Perryville, Mo.</u>	ADDRESS
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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 _____

John Ketter

Licensed Embalmer No. 3880

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.