

EV. 10.48 FILED DEC 12 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40611

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10608

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS MO</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>0500</b>	
c. LENGTH OF STAY (in this place) <b>9 DAYS</b>		d. STREET ADDRESS (If rural, give location) <b>R.R. 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) <b>BERNIECE PILLAR</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 17 1952</b>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 20 1899</b>	9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>KENTUCKY</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>WILLIAM GOLDSMITH</b>	13b. MOTHER'S MAIDEN NAME <b>BELL MAY TUTTLE</b>	14. NAME OF HUSBAND OR WIFE <b>WALTER J. PILLAR</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>WALTER J. PILLAR</b>	ADDRESS <b>R.R. 1 ARNOLD MO</b>
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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) <b>Cerebral Apoplexy</b>	DUE TO (b) <b>Arterio Sclerotic Myocarditis</b>		<b>Sudden</b>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) <b>Generalized Arterio Sclerosis</b>		<b>4 yrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Heart's Infiltrates</b>			<b>4 yrs</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? (YES <input type="checkbox"/> NO <input type="checkbox"/> )
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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)
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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? <b>4221</b>
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22. I hereby certify that I attended the deceased from **Apr 19 48** to **11/17/52**, that I last saw the deceased alive on **11/17, 1952**, and that death occurred at **8:40 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>C. H. Duerksen M.D.</b>	(Degree or title)	23b. ADDRESS <b>5203 Chippewa</b>	23c. DATE SIGNED <b>11/18/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>Nov. 20 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
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DATE REC'D BY LOCAL REG. <b>NOV 18 1952</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kutis</b>	ADDRESS <b>2906 Harris</b>
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512 (Licensed Embalmer's Statement on Reverse Side)

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

5203 Westview  
The 8028<sup>6</sup>  
Mo. after 1<sup>30</sup> pm  
Jews on the (no for others)

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

*Leo J. Buddle*

Licensed Embalmer No. *3989*

P. O. Address

*St. Louis Mo*

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.