

FILED JAN 26 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44777
Registrar's No. 11994

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. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		2139
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital			d. STREET ADDRESS (If rural, give location) 13 5100 Arsenal St.		
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA		b. (Middle) _____	c. (Last) CRESSEY	4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH 3/5/1900	9. AGE (In years last birthday) 52	# UNDER 1 YEAR # UNDER 1 MONTH # UNDER 1 HOUR # UNDER 1 MIN.
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 (City and State or Foreign Country) ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME AUGUST FARK		13b. MOTHER'S MAIDEN NAME BERTHA KOEHLER		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) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME AUGUST FARK		
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.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism ANTECEDENT CAUSES DUE TO (b) Paresis 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 45 min 2/4/46x
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 025X		
22. I hereby certify that I attended the deceased from Feb. 4, 1946 , to Dec. 28, 1952 , that I last saw the deceased alive on Dec. 28, 1952 , and that death occurred at 6:45p m., from the causes and on the date stated above.					
23a. SIGNATURE <i>Anna Hyman</i> MD			23b. ADDRESS 5100 Arsenal St.		23c. DATE SIGNED 12/29/52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12/30/51	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. DEC 29 1952		REGISTRAR'S SIGNATURE <i>J. C. Smith</i> MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AV		

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address Shrewsboro

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.