

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5916

FILED MAR 15 1954

State File No.

2046

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

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 OR TOWN (If outside corporate limits, write RURAL and give township) <u>St Louis Mo</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>St Louis</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>26 809 Wright Str.</u> 2269 0		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Verna</u> b. (Middle) <u>Betty</u> c. (Last) <u>Bermiester</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-25-54</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>D</u>	8. DATE OF BIRTH <u>Dec 9 1914</u>		9. AGE (In years last birthday) <u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>***</u>		11. BIRTHPLACE (State or foreign country) <u>Campbel Mo</u>		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Goldie Haygood</u>		14. NAME OF HUSBAND OR WIFE <u>*****</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William Glenn Sharp 935 Hickory</u>			

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)		DUE TO (b) <u>Aspiration Pneumonia</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Septicemia (Non Traumatic)</u>			
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			20. AUTOPSY? YES <input checked="" 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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0534</u>		

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 1055 P.M., from the causes and on the date stated above.

23. SIGNATURE <u>Joseph M. Quinn</u> (Degree or title)		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>3/5/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>3-5-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Mathews</u>	
				24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	

DATE REC'D BY LOCAL REG. <u>MAR 5 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Central Und Co 1841 Cass ave</u>	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

25

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 _____

Licensed Embalmer No. Not Embalmed

P. O. Address J.J Stygar P.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

