

STANDARD CERTIFICATE OF DEATH

9865

State File No.

2885

FILED APR 2 1954

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 7 Days	c. CITY OR TOWN St. Louis, Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Jewish Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS		(If rural, give location) 5551 Robin Avenue,	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Wilbert	b. (Middle)	c. (Last) Bachhaus	(Month) March (Day) 28, (Year) 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 27, 1907
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Herman C. Bachhaus	13b. MOTHER'S MAIDEN NAME Theresa Kessing,	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) Yes 2nd W.W.	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Agnes Bachhaus, 5049 Davison Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 days
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage		DUE TO (b) _____		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		none		

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) 330X
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 March 22, 1954, to March 28, 1954, that I last saw the deceased alive on March 27, 1954, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles Silverberg, M.D.	23b. ADDRESS 462 N. Taylor, St. Louis, Mo.	23c. DATE SIGNED 3/29/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-31-1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery,
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.		

DATE REC'D BY LOCAL REG. MAR 30 1954	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Math. Hermann & Son Inc.	ADDRESS 2161 E. Fair Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Walter G. Burns*.....
Licensed Embalmer No. *420*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.