

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1954

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 923

0923

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

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution? residence before death?) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Charles	
c. LENGTH OF STAY (in this place) 5 1/2 yrs.		d. STREET ADDRESS (If rural, give location) 317 Lindenwood	
d. FULL NAME OF HOSPITAL OR INSTITUTION 317 Lindenwood			

3. NAME OF DECEASED (Type or Print) Louise Bernhoester	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) April 18, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 12, 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 7 Days 6	IF UNDER 1 HR. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Christ Roedenbeck	13b. MOTHER'S MAIDEN NAME Anna Heidbrinck	14. NAME OF HUSBAND OR WIFE Henry Bernhoester
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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 ADDRESS Mrs. Melvin Schutten, St. Charles, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis		4 years
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 type="checkbox"/> NO <input checked="" 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?
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22. I hereby certify that I attended the deceased from Feb 1934, to April 19, 1954, that I last saw the deceased alive on April 16, 1954, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Vincent A. Schneider M.D.	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED Apr 19-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 22, 1954	24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	24d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
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DATE REC'D BY LOCAL REG. April 19 1954	REGISTRAR'S SIGNATURE F. J. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.C. Dellinger & Sons, St. Charles, Mo.
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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 *Frank R. Amalong*

Licensed Embalmer No. *4832*

P. O. Address *St. Charles, 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.