

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**13154**

State File No. ....

FILED APR 21 1954

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1807

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>Saint Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>2428 Leffingwell Ave.</b>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>EDWARD</b>	b. (Middle) <b>H.</b>	c. (Last) <b>BARTLING</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>FEBRUARY 23, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 28, 1884</b>	9. AGE (In years last birthday) <b>69</b>	If UNDER 1 YEAR: Months _____ Days _____	If UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Indianapolis, Ind</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Bartling</b>	13b. MOTHER'S MAIDEN NAME <b>not known</b>	14. NAME OF HUSBAND OR WIFE <b>Mabel L. Bartling</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>309-12-2644</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mabel Bartling</b>	ADDRESS <b>2438 Leffingwell Ave.</b>
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia Broncho Bacterial</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis of Aorta</b>		
	DUE TO (c) <b>Hypertensive Cardiovascular Dis</b>		
11. 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"/>
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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>4200</b>
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22. I hereby certify that I attended the deceased from **1-20-54**, 19**54**, to **2-23-54**, 19**54**, that I last saw the deceased alive on **2-23-54**, 19**54**, and that death occurred at **11:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Phillip Comens MD</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>2-23-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Feb. 26, 1954</b>	24c. NAME OF CEMETERY OR-CREMATORY <b>New Bethlehem</b>	24d. LOCATION (City, town, or county) (State) <b>9600 Bellefontaine Rd.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 25 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>CRAIG</b>	ADDRESS <b>4500 Washington.</b>
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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..... *E. Cournot Reme*

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.