

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21089**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4955**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri.</b> b. COUNTY <b>2109</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>7</b>	c. CITY OR TOWN <b>St. Louis,</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4129 Penrose Ave.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>4129 Penrose Ave.</b>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Bertha</b>	b. (Middle) <b>Ann</b>	c. (Last) <b>Pfleger</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 2, 1954</b>
5. SEX <b>Female /</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow 2</b>	8. DATE OF BIRTH <b>Feb. 17, 1874</b>
9. AGE (in years last birthday) <b>80</b>		IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Saxony Germany 7</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Fred Guendel.</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Mueller</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph</b>
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>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Bert Johnson, 5541a Ashland</b>

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 <b>6 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Apoplexy</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Cardiac Decompensation</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
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"/>
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? <b>334X</b>

22. I hereby certify that I attended the deceased from **May 21st, 1954**, to **June 2nd, 1954**, that I last saw the deceased alive on **June 2nd, 1954**, and that death occurred at **2:55 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Victor K. Kuntzsch D.C. I</b>	23b. ADDRESS <b>3407 S. Grand Blvd.,</b>	23c. DATE SIGNED <b>6-3-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-5-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>		

DATE REC'D BY LOCAL REG. <b>JUN 4 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>
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S.P. (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 *J. Wm B. Embley*

Licensed Embalmer No. *365*

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.