

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30533

8668

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 <i>Missouri</i>		b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>ST. LOUIS, MISSOURI.</i>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <i>ST. LOUIS</i>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL.</i>		e. STREET ADDRESS (If rural, give location) <i>23 2202 Missouri 22390</i>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or Print) <i>BERNICE</i>			a. (First)	b. (Middle)	c. (Last) <i>ABERTER</i>	
4. DATE OF DEATH <i>OCT. 4, 1955.</i>		(Month)	(Day)	(Year)		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>FEB. 16 1914</i>	9. AGE (In years last birthday) <i>41</i>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <i>ST. LOUIS Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>MAX JASKIEWICZ</i>		13b. MOTHER'S MAIDEN NAME <i>CAROLINE DZICPAK</i>		14. NAME OF HUSBAND OR WIFE <i>UNKNOWN</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>497-09-7001</i>	17. INFORMANT'S SIGNATURE OR NAME <i>HELEN BUHLINGER</i>		ADDRESS <i>2202 Missouri</i>		
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>metastatic carcinoma of ovary, glandular</i>				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)	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 <i>171x</i>				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) m.	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 <i>9-28-</i> 19 <i>55</i> , to <i>OCT. 4,</i> 19 <i>55</i> , that I last saw the deceased alive on <i>10-4-</i> 19 <i>55</i> , and that death occurred at <i>7:05 a.m.</i> , from the causes and on the date stated above.						
23. SIGNATURE (Degree or title) <i>Rhysa Williams, M.D.</i>		23b. ADDRESS <i>1515 LAFAYETTE AVE.</i>		23c. DATE SIGNED <i>10-4-55.</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>OCT 7 1955</i>	24c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM</i>	24d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>			
DATE REC'D BY LOCAL REG. <i>OCT 4 1955</i>	REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas Kates</i>		ADDRESS <i>2906 Maroon</i>		

(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 *James E. Del...*

Licensed Embalmer No. *43*

P. O. Address *2906*

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.