

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH10409  
State File No. ....  
Registrar's No. .... 2172

|   |  |  |   |   |  |   |  |  |         |  |  |
|---|--|--|---|---|--|---|--|--|---------|--|--|
| BIRTH NO. ....  |  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. .... <b>2172</b>  |  |  |         |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY   |  |   |  |  |         |  |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS, MISSOURI</b> )   |  | c. LENGTH OF STAY (In this place) <b>8-days</b>  |   | c. CITY OR TOWN <b>St. Louis</b>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |         |  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>   |  |  |   | e. STREET ADDRESS (If rural, give location) <b>15 4364 Delor St. 21590</b>  |  |   |  |  |         |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>AMELIA</b>   |  |  | b. (Middle) <b>M.</b>   |   | c. (Last) <b>BARTZ</b>   |   | 4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 28, 1956</b> |  |         |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   |  | 8. DATE OF BIRTH <b>Aug. 7, 1879</b>  |  | 9. AGE (In years) (Months) (Days) (If under 1 year) (If under 24 hrs.) <b>76</b> |         |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>                                  |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>                         |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                       |         |  |  |
| 13a. FATHER'S NAME <b>John P. Sehnert</b>   |  |  | 13b. MOTHER'S MAIDEN NAME <b>Louisa Tschannon</b>                                 |   |  | 14. NAME OF HUSBAND OR WIFE <b>Frank Bartz</b>  |  |  |         |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>197-38-7220</b> |   | 17. INFORMANT'S SIGNATURE OR NAME <b>Vera Hoover - 3851a DeTonty St.</b>                   |   |  |  | ADDRESS |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                          |  |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hemolytic anemia</b><br><b>Hemolytic Anemia</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |         |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   |   |  |   |  |  |         |  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION <b>292.2</b>  |   |   |  |   |  | 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)   |  | 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 <b>2-20, 1956</b> , to <b>2-28, 1956</b> , that I last saw the deceased alive on <b>2-28, 1956</b> , and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above. |  |  |   |   |  |   |  |  |         |  |  |
| 23a. SIGNATURE <b>Robt. Denton</b>  |  |  |   | 23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>   |  |   |  | 23c. DATE SIGNED <b>2-28-56.</b>   |         |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24b. DATE <b>Mar. 2, 1956</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>  |  |  |         |  |  |
| DATE REC'D BY LOCAL REG. <b>MAR 1 1956</b>  |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith m.d.</b>  |   |   | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Wacker-Keldarke</b> ADDRESS <b>- 3634 Gravois Ave.</b> |   |  |  |         |  |  |

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

VS APR 19 1961

**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 *Robert Wheeler*.....

Licensed Embalmer No.....*2*

P. O. Address *Stennis*.....

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.