

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9915
STATE FILE NUMBER 2142

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O/ 4152 Westminster			Length of stay in lb 2/99		d. STREET ADDRESS (If outside, give location) 4152 Westminster		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERT Middle Last BERNARD				4. DATE OF DEATH Month Feb. Day 25 Year 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		
9. AGE (In years last birthday) Abt. 50		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and state or country) Indiana		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Ruth Bernard-4152 Westminster Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cirrhosis of the Liver; DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None, Place and Manner of the same could not be determined						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1040 P m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree & title) Patrick J. Taylor Coroner				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3. 4. 57.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/4/57		23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc., 5216 Delmar				25. DATE RECD. BY LOCAL REG. MAR 4 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

5. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

referred to this

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the body of the

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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 emb

by me, or by Student Embalmer No.....

working under my personal supervision.

Student
Signature of Student Embalmer

Handwritten signature of student embalmer

Signed
Signature of Licensed Embalmer

Handwritten signature of licensed embalmer

Licensed Embalmer No. *769*

P. O. Address *S. Lang*

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