

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044696

STATE FILE NUMBER

FILED JAN 13 1959

Registration District No. 162

Primary Registration District No. 5595

Registrar's No. 117

300 4  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Imperial</u>		c. CITY OR TOWN <u>Cedar Hill</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Our Oaks Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>	

3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Pink</u> Last <u>Pink</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>58</u>			
--	--	--	---	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31st, 1870</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.
----------------------	-------------------------------	---	---	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cedar Hill, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	---	---

13a. FATHER'S NAME <u>David Bergner</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>George Pink, Arnold, Mo.</u>	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) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>27 days</u>
DUE TO (b) <u>Ant tro charteric fracture left femur</u> DUE TO (c) <u>Generalized Arterio sclerosis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arterio sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
---	--	--

20a. ACCIDENT <input 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.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION <u>Os</u> COUNTY _____ STATE _____
---	--	---

21. I attended the deceased from <u>12/6/58</u> to <u>12/29/58</u> and last saw her alive on <u>12/24/58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Do not write title) <u>Frank Duck M.D.</u>	22b. ADDRESS <u>Fenton, Mo.</u>	22c. DATE SIGNED <u>12/30/58</u>
---	------------------------------------	-------------------------------------

23a. BURIAL, (Specify) <u>Removal</u>	23b. DATE <u>JAN 2 - 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL BAPTIST CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CEDAR HILL, MISSOURI</u>
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>Frohwitter-Miller</u>	ADDRESS <u>High Ridge, Mo</u>	25. DATE RECD. BY LOCAL REG <u>1-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>
--	----------------------------------	--	---

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

44  
5

JAN 13 1959  
APR 8 1959

DATE RECEIVED JAN 8 1959

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 *Neville B Frohwitter* .....

Licensed Embalmer No. *3496* .....

P. O. Address *High Ridge* .....

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.