

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1960

318

Primary Registration District No. 1003

Registrar's No.

8294

-60-031882

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 1/2 years</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5459 Arlington Ave</u>				d. STREET ADDRESS (If outside, give location) <u>5459 Arlington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle Last <u>BERGER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1895</u>	9. AGE (last birthday) <u>64 years</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ellis Grove, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Charles Henderson</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Oliver</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Berger</u>		
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>490-03-5384B</u>		17. INFORMANT <u>Joseph Berger - 5459 Arlington Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis due to</u> DUE TO (b) <u>Carcinoma of Nasopharynx 1 year</u> DUE TO (c) <u>146x</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.		Month, Day, Year					
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.)		21. CITY, TOWN, OR LOCATION <u>Present</u>		COUNTY	STATE
21. I attended the deceased from <u>1958</u> , to <u>Present</u> , and last saw her <u>alive on 8/20/60</u> Death occurred at <u>6 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. J. Boed M.D.</u>		(Degree or title)		22b. ADDRESS <u>Northland Med Bldg</u>		DATE SIGNED <u>8/23/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>August 26, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>BUCHHOLZ MORT. - 5967 West Florissant Ave.</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 23 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith. M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter J. Buchholz

Licensed Embalmer No. 25537

P. O. Address St. Louis

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