

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017365

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3975**

STATE FILE NUMBER

FILED APR 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 6 weeks	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Edgewater Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4350a Linton Avenue
3. NAME OF DECEASED (Type or print)		First Selma	Middle Berndt
4. DATE OF DEATH		Month April	Day 6 Year 1963
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1887
9. AGE (last birthday) 75		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Herman Kastrup	
13b. MOTHER'S MAIDEN NAME Louise Schnuck		14. NAME OF HUSBAND OR WIFE deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of)		17. INFORMANT Mrs. Ruth Eisenhauer, 2020 E. Gano Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Bronchial Pneumonia		4 5 days	
DUE TO (b)			
DUE TO (c) 791x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascular Accidents		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	
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from Feb. 22, 1963 to April 6, 1963 and last saw her ^{her} alive on April 6, 1963 Death occurred at 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert Sanders, M.D.		22b. ADDRESS 5500 S. Broadway	22c. DATE SIGNED 4-8-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE April 9 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
25. DATE RECD. BY LOCAL REG. APR 9 1963		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	
FUNERAL DIRECTOR ADDRESS Mach Herbrand & Son, Inc., 2161 E. Fair Ave St. Louis, Missouri			

USE BLACK INK
OR
TYPEWRITER RIBBON

86

100-30-100

MAY 20 1963

x St. Louis
 x 4332 Johnson Avenue
 x 7-26-1961
 x 4332 Johnson Avenue
 x 7-26-1961
 x 4332 Johnson Avenue
 x 7-26-1961

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 Walter B. Burnley

Licensed Embalmer No. 4282

P. O. Address St. Louis, Mo.

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.

Missouri State Board of Health
 100 North 2nd Street
 St. Louis, Missouri 63102