

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050149

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3965

FILED JAN 9 1964

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4036

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pine Lawn</u>		c. CITY OR TOWN <u>St Louis</u>	
Length of stay in 1b		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>Schamrock Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>3503 Bailey Ave</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Berger</u>			4. DATE OF DEATH Month Day Year <u>Dec 24 1963</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>2/9/1887</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Stansalius Wonsenic</u>	
13b. MOTHER'S MAIDEN NAME <u>Barbara Bosek</u>		14. NAME OF HUSBAND OR WIFE <u>Max Berger (Deed)</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>[redacted]</u>	
17. INFORMANT <u>Herman Jones</u>		Address <u>3503 Bailey Ave</u>	
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 infarctions, multiple</u>			INTERVAL BETWEEN ONSET AND DEATH <u>over 1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive and arteriosclerotic</u>			DUE TO (c) <u>Cardiovascular disease</u>
DUE TO (a) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenocarcinoma Right Breast</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
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.) <u>443 x H</u>	
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 <u>Feb 26, 1963</u> to <u>Dec 24, 1963</u> and last saw her alive on <u>Dec 23, 1963</u> Death occurred at <u>1.45P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Lewis Littmann MD</u> (Degree or title)		22b. ADDRESS <u>665 So Skinner Blvd (5)</u>	22c. DATE SIGNED <u>12/27/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec 28 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cem.</u>	23d. LOCATION (City, town, or county) <u>St Louis Mo.</u>
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>12-26-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>

03-10-1975

Dr. ~~Stittman~~
665 S. ~~Stittman~~
FIRST FLOOR
Pa. 19002

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 Ja. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Grassi

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.