

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1008311
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 311
(c) City St. Louis, Mo. (d) Street No. St. Anthony's Hospital St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth yrs. mos. ds.

2. PRINT FULL NAME Mary Bernal

(a) Residence, No. 4721 Ashland Ave. St. 6
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Bernal

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs.min.
About 75 Unknown Unknown

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland13. NAME Unknown14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland17. INFORMANT (ADDRESS) George Cepicky
4228 Castleman18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE Jan. 11, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Moydell
1926 Allen Ave.20. FILED JAN 10 1939
J. T. Brudeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 8, 193922. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1938, to Jan 8, 1939I last saw her alive on Jan 8, 1939. Death is said to have occurred on the date stated above, at 3:15a

The principal cause of death and related causes of importance were as follows:

Broncho-Pneumonia
Embolic infarction of the lungs
Arterio sclerosis
Paralysis of left foot

Other contributory causes of importance:

Date of onset

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? No23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury.....
Nature of injury.....24. Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Stephen M. Trappes, M. D.
(Address) 2617 N. 14th St.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Benj. C. Duncan
Licensed Embalmer No. 2272
P. O. Address 1926 Allen

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 this body is not embalmed, above space should be left blank.