

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **791**
1003 Primary Registration District No. **791**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution: **City Hospital, #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether
In this community **30 years**
years, months or days)

3. (a) PRINT FULL NAME **Rosa Herchert 126**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color of race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Fred. Herchert** 6. (c) Age of husband or wife if alive **51** years
7. Birth date of deceased **April 27 1885**
(Month) (Day) (Year)

8. AGE: Years **54** Months **6** Days **-** If less than one day _____ hr. _____ min.

9. Birthplace **Blauvelt, N.Y.** (City, town, or county) **Mo.** (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____
MOTHER FATHER { 12. Name **Perry Kornfeldt**
13. Birthplace **Germany**
14. Maiden name **Pauline Sabarsky**
15. Birthplace **Germany**

16. (a) Informant's own signature **Rosa Herchert**
(b) Address **4647 Virginia**

17. (a) **Crema** (b) Date thereof **Oct. 27 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Paul's Churchyard**

18. (a) Signature of funeral director **Frederick J. Biedeck**
(b) Address **1906 St. Louis Ave**

19. (a) **OCT 26 1939** (b) **J. F. Biedeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis 15**
(If outside city or town limits, write "RURAL")
(d) Street No. **4647 Virginia**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **24**,
year **1939** hour **12:55** minute _____ P. M.

21. I hereby certify that I attended the deceased from **October 23**, 1939, to **October 24**, 1939
that I last saw her alive on **October 24**, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Due to **Hypertension**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Geo. W. Pule** (M. D. or other) _____
Address **1515 Lafayette, St. Louis 34**

MAR 18 1954

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.....

Licensed Embalmer No. *3737*

P. O. Address *1936 St. James Ave*

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.