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S. No. 2  
1-14-41  
5-17-39  
X28390

MAY 13 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13276  
Registrar's No. 3706

Registration District No. 791

Primary Registration District No. 1003

10  
17  
9  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 Days  
In this community LIFE  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County 000  
(c) City or town ST. LOUIS 1710  
(d) Street No. 4015 A. LABADIE AVA  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bertha Heil  
3. (b) If veteran, name war NONE  
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 28,  
year 1941 hour 7:50 minute P. M.  
21. I hereby certify that I attended the deceased from April  
19, 19 41 to April 28, 19 41  
that I last saw her alive on April 28, 19 41  
and that death occurred on the date and hour stated above.

4. Sex FEMALE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: MCH. 16<sup>th</sup> 1856  
(Month) (Day) (Year)

Immediate cause of death  
Carcinoma of Oesophagus  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
85 1 12 — hr. — min.

Other conditions (Include pregnancy, tuberculous meningitis, etc.)  
arteriosclerosis  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy aut

9. Birthplace ST. LOUIS MO.  
(City, town, or county) (State or foreign country)  
10. Usual occupation RETIRED JANITRESS  
SCRUGS-VADEVOORTS  
11. Industry or business \_\_\_\_\_  
12. Name PETER HEIL  
13. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)  
14. Maiden name VERONICA KLEVER  
15. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Margaret Callahan  
(b) Address 4015 A Labadie  
17. (a) BURIAL (b) Date thereof MAY 12 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY  
Brockland and Co  
18. (a) Signature of funeral director 1827 HOGAN STR.  
(b) Address \_\_\_\_\_  
19. (a) APR 30 1941 (b) J T Brechler  
(Data received local registrar) (Registrar's signature)

23. Signature [Signature] M.D. of pathologist  
Address 2515 Lafayette Avenue Date signed 4/28/41

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**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..... *Wilford H. Burnley*  
Licensed Embalmer No..... *4202*

P. O. Address.....

**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, fact should be so stated above.**