

FILED JAN 10 1944

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town Baden  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. 4 #452 Lord (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bertha Heidenreich  
3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Louis Heidenreich 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased 3-1-1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
49 9 28 hr. min.

9. Birthplace Benton Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business --

MOTHER FATHER { 12. Name Unknown Cook  
13. Birthplace Unknown unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Heidenreich  
(b) Address Chamber St & Lind Drive

17. (a) Burial (b) Date thereof Jan. 3, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Reiderwieden F. H. Inc.

(b) Address 1936 St. Louis Ave.

19. (a) JAN 3 - 1944 (b) E. G. McHarran, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-31-43 day \_\_\_\_\_  
year \_\_\_\_\_ hour 8:15 minute A. M.  
21. I hereby certify that I attended the deceased from 12-29-43, 19\_\_\_\_, to 12-31-43, 19\_\_\_\_,  
that I last saw her alive on 12-31-43, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chrd. failure +  
pulm congestion 2 days  
Due to bronchitis 1-2 yrs  
& fibrosis of lungs  
Due to asthma 5 yrs  
lues 2 yrs

Other conditions (include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 309

Duration  
2 days  
1-2 yrs  
5 yrs  
2 yrs  
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) (Means of injury)

23. Signature [Signature] M. D. or other \_\_\_\_\_  
Address St. Louis County Hospital Date signed 12-31-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

76  
2  
3

JAN 24 1944

FEB 1 1944

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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..... *Delis J. Krissin* .....

Licensed Embalmer No. *3497* .....

P. O. Address. *1936 St Louis* .....

**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.