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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR 27 1944

Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **2772**

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St. Louis,**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**3830 Lee Ave. /**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County.....

(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3830 Lee Ave.**  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Bertha Dausch.**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow.**

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **July 20, 1873**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>70</b>	<b>8</b>	<b>1</b>	..... hr. min.

9. Birthplace **St. Louis, Missouri.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework.**

11. Industry or business.....

12. Name **Conrad Alt.**

13. Birthplace **Germany.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bertha Wolfrauth**

15. Birthplace **Missouri.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Emilie Boyd**

(b) Address **3830 Lee Ave.**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **March 24, 1944**  
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Johns Cemetery**

18. (a) Signature of funeral director **Reuben J. ...**

(b) Address **1431 Union Blvd.**

19. (a) **MAR 23 1944** (Date received local registrar)

**J. W. ...** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **21**  
year **1944** hour **7** minute **30 p. M.**

21. I hereby certify that I attended the deceased from **3-5-44**  
....., 19....., to **3-21-44**, 19.....;

that I last saw her alive on **3-21-44**, 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Chronic myocarditis** don't know

Due to..... **none**

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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.....  
**Wallerth & Socrensen M.D.** (M. D. or other)

Address **1506 St. Louis** Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3-25-44

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

State of  
New York

County of

08

*Wm. Spornman*  
*1506 57 Ave*

**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

working under my personal supervision.

Registered Apprentice No.

Signed

*Frederick Heber*

Licensed Embalmer No.

*2915*

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.