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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12 1945

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42067

Primary Registration District No. 2002

Registrar's No. 2541

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 717 Syracuse
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96

(c) City or town University City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 717 Syracuse 5
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 11

3. (a) PRINT FULL NAME Bertha C. Bernstein

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female

5. Color or race white

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

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

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

7. Birth date of deceased Aug. (Month) 1, (Day) 1879 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	4	12	hr. min.

9. Birthplace Sedalia, (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Wm. Czarlinsky
13. Birthplace (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Amelia Czarlinsky
15. Birthplace (City, town, or county) Germany (State or foreign country) 4

16. (a) Informant Winifred Bernstein

(b) Address 717 Syracuse

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/15/44 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo.

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave.

19. (a) DEC 15 1944 (Date received local registrar) (b) E. G. McGavran M.D. (Registrar's signature) CMB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13
year 1944 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from 7/7, 1943 to Dec 13, 1944
that I last saw her alive on Nov. 27, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to Hypertension

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: sudden

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?
(Specify type of place)

While at work? (e) Means of injury

Signature Alfred Gladman (M. D. or other) M D

Address 634 N. Grand Date signed 12/13/44

(Licensed Embalmer's Statement on Reverse Side)

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. 1597

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.