. S. No. 2
M—12-45
v. 5-17-39
1 X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10744

Registration District No. #68302 318

Primary Registration District No. 1003

Registrar's No. 3123

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-Max C. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Weeks (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. 2720a S. Jefferson Ave. Memorial (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME BERTHA DIETHELM

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 Ernest

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased April (Month) 14 (Day) 1898 (Year)

8. AGE: Years 48 Months 11 Days 9 If less than one day hr. min.

9. Birthplace Hainesport (City, town, or county) New Jersey (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Adam Washkivtz
13. Birthplace (City, town, or county) Poland (State or foreign country) 4

MOTHER
14. Maiden name Agnes Malchareck
15. Birthplace (City, town, or county) Poland (State or foreign country) 4

16. (a) Informant Ernest Diethelm
(b) Address 2720a S.Jefferson Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (Month) (Day) (Year)
(c) Place: burial or cremation New St.Marcus Cemetery

18. (a) Signature of funeral director John H. Gibbons
(b) Address 2630 Gravois Ave.

19. (a) MAR 24 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd year 1947 hour 12:30 minute P M.

21. I hereby certify that I attended the deceased from 2/17/47, 19, to 3/23/47, 19; that I last saw her alive on 3/23/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Internal hydrocephalus (left - advanced).

Due to Cause undetermined

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Report not complete

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M.D. or other) M.D.

Address 1515 Lafayette Date signed 3/24/47

(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 Robert F. Gebhen

Licensed Embalmer No. 4144

P. O. Address 2630 Grand 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, fact should be so stated above.