

No. 300
1-10-47
5-17-39
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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28293**
Registrar's No. **7808**

FILED SEP 13 1948
Registration District No. **010**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Anthony Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Marie Josephine Ververloh

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 Cornilius

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

7. Birth date of deceased: Feb. 15 1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>51</u>	<u>6</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation: At. Home

11. Industry or business: _____

12. Name: August Merkel

13. Birthplace: St. Louis Mo
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Bernhard

15. Birthplace: St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant: Cornilius Ververloh

(b) Address: 2220 Indiana Ave.

17. (a) Burial (b) Date thereof: 9/7/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: SS. Peter & Paul Cem.

18. (a) Signature of funeral director: John H. Gebken Sons

(b) Address: 2630 Gravois

19. (a) SEP 13 1948 (b) J. F. Breeseck
(Date received local registration) (Registrar's signature)

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. 2220 Indiana Ave.
23 (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 1948 hour 12 minute 45 PM

21. I hereby certify that I attended the deceased from Jan 1, 1948 to Sept 4, 1948
that I last saw her alive on Sept 7, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Accident

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 _____

23. Signature: John W. Wanker (M. D. or other) M.D.
Address: 3318 S. Grand Date signed: 9-4-48

33185-1000

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. Gibben

Licensed Embalmer No. 4144

P. O. Address 2630 Grassie

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.