

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Manchester Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs
In this community 3 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96
(c) City or town Manchester (If outside city or town limits, write "RURAL") 0
(d) Street No. Nursing Home (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME BERTHA Keller.

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 Wid 2

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

7. Birth date of deceased Feb 11 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 7 9 hr. min.

9. Birthplace Du Bois Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

12. Name Peter Brod

13. Birthplace Du Bois Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Margaret

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

16. (a) Informant Paul Keller

(b) Address 2807 No Grand

17. (a) Removal (b) Date thereof 9-21-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oden Ill

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester

19. (a) 9-21-48 (b) Gene G. Hapgood
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1948 hour 3:15 minute P M.

21. I hereby certify that I attended the deceased from Feb 3
1946 to Sept 20, 1948
that I last saw her alive on Sept 19, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
Chr. Myocarditis
Heart Arteriosclerosis

Due to 93d

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

3. Signature Ch Denny (M. D. or other) MD
Address Crews Crew, Miss Date signed 9-20-48

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

MOTHER FATHER

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.....

Ken M. Spencer

Licensed Embalmer No.....

4343

P. O. Address.....

St Louis Mo.

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.