

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **137753**
Registrar's No. **3334**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (in this place) 1 week		d. STREET ADDRESS (If rural, give location) 5637 Rhodes	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony			

3. NAME OF DECEASED (Type or Print) a. (First) Bertha b. (Middle) c. (Last) Flick		4. DATE OF DEATH (Month) (Day) (Year) April 11, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 15, 1885
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	11. BIRTHPLACE (State or foreign country) St Louis, Mo. U
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME George Ernst	13b. MOTHER'S MAIDEN NAME Ana Kuenemeyer	14. NAME OF HUSBAND OR WIFE Frank P Flick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Frank P Flick ADDRESS 5637 Rhodes

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Apoplexy Rt.		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-vascular renal syndrome DUE TO (c) marked hypertension		Several years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from **10/4**, 19**43**, to **4-11**, 19**49**, that I last saw the deceased alive on **4-10**, 19**49**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Wm J. Wolkawa M.D. (Degree or title)	23b. ADDRESS 3809 W. Livingston Ave. St. Louis 16 Mo	23c. DATE SIGNED 4-12-49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 4/14/49	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
24d. LOCATION (City, town, or county) (State) St Louis County, Mo.		

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 14 1949 J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE L Ziegenhein & Sons ADDRESS 7027 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed W. G. Peterson

Signed.....
Student Embalmer

Licensed Embalmer No. 3767

P. O. Address 7027 Gravois

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.