

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17074

1003 State, File No. 4592

#97627

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 4053 Alma Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Benjamin b. (Middle) BEN c. (Last) BERTOLT			4. DATE OF DEATH (Month) (Day) (Year) May 23rd, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED; (Specify) Widow	8. DATE OF BIRTH May 14th, 1863
9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank Bertolt		13b. MOTHER'S MAIDEN NAME Agnes ???	14. NAME OF HUSBAND OR WIFE *****
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. 493-10-1995 A	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julia Hofman 4207 A DeTonty St	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 93rd	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1/20th	
22. I hereby certify that I attended the deceased from 5/16/49 to 5/23/49 , 19____, that I last saw the deceased alive on 5/23/49 , 19____, and that death occurred at 8:30am , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas. S. Bryan, M.D.		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 5/23/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-26-1949	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) 7600 St. Charles Rock Road Mo.
DATE REC'D BY LOCAL REG. MAY 24 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ziegenhein Bros. 6409 Gravois Ave	

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

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Henry M. Brunner

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.