

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24594  
6176

318

10002

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ 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 Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		b. COUNTY St. Louis	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6257 Eichelberger		d. STREET ADDRESS (If rural, give location) 6257 Eichelberger	

3. NAME OF DECEASED (Type or Print) James	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH July 15, 1949
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4, 1905	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jacob Bernhardt	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Collette
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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 Collette Bernhardt, 6257 Eichelberger	ADDRESS 6257 Eichelberger
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH 3 mo (?)
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary artery disease</i>		
	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 checked="" type="checkbox"/>
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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) 9400
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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? H201
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22. I hereby certify that I attended the deceased from 7/2, 1949, to 7/15, 1949, that I last saw the deceased alive on 7/12, 1949, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE Edward W. Gebinski M.D.	(Degree or title)	23b. ADDRESS 3701 Grandel Square	23c. DATE SIGNED 7/15/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/18/49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery, St. Louis Co., Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JUL 15 1949	REGISTRAR'S SIGNATURE J B Lavater	FUNERAL DIRECTOR'S SIGNATURE Wacker Felder H. Co., 3634 Acacia	ADDRESS
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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.

Student .....  
Student Embalmer

Signed

*Delis J. Krispin*

Licensed Embalmer No. ....

*3497*

P. O. Address

*3634 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.