

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39150

FILED NOV 21 1949

State File No. 9653

318

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9653

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 <u>Missouri</u> b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		_____							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3136 Hawthorne</u>				d. STREET ADDRESS (If rural, give location) <u>17- 3136 Hawthorne ave</u>									
3. NAME OF DECEASED a. (First) <u>Martha</u>			b. (Middle) _____		c. (Last) <u>Ohrndorf</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 8 1949</u>						
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>Aug. 28 1859</u>		9. AGE (in years last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u>		IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Breslan Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>4</u>			
13a. FATHER'S NAME <u>Robert Skinski</u>				13b. MOTHER'S MAIDEN NAME <u>unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Charles W. Ohrndorf</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harriet A. Broeker 3136 Hawthorne Bl.</u>							
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u> ANTECEDENT CAUSES <u>arteriosclerotic heart disease.</u> Morbid 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.								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
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) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>922</u>									
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? <u>4221</u>									
22. I hereby certify that I attended the deceased from <u>Nov. 7, 1949</u> , to <u>Nov. 8, 1949</u> ; that I last saw the deceased alive on <u>Nov. 7, 1949</u> , and that death occurred at <u>9:52 a.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <u>H. F. Bergman M.D.</u>				23b. ADDRESS <u>3220 Washington</u>				23c. DATE SIGNED <u>11/9/49</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		24b. DATE <u>Nov. 10, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Walhalla Crematory</u>				24d. LOCATION (City, town, or county) (State) <u>St. Charles Rd St. L. Mo</u>					
DATE REC'D BY LOCAL REG. <u>NOV 9</u>				REGISTRAR'S SIGNATURE <u>R. B. Blaster</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A. Krow La U. Co. 2707 N. Grand Blvd.</u>					

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

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**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 Stanley H. Dixon

Licensed Embalmer No. 41913

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.