

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED MAR 8 1950

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 63

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Farmington</u> TOWN <u>RURAL</u> St. Francois | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>2850 Lyndhurst, St. Louis County</u> | |
| c. LENGTH OF STAY (in this place) <u>14Y; 9M; 23D</u> | | d. STREET ADDRESS (If rural, give location) <u>See above.</u> <u>4190</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4.</u> | | | |

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|---|----------------------------------|--|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>BERTHA</u> b. (Middle) <u>MAY</u> c. (Last) <u>SLATTERY</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 20, 1950</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 2, 1895</u> | 9. AGE (In years last birthday) <u>55</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Vulcan County, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |

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|---|--|---|--|---|--|---------|--|
| 13a. FATHER'S NAME <u>George Wigglesworth</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nellie Merdeith</u> | | 14. NAME OF HUSBAND OR WIFE <u>William F. Slattery</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital No. 4, Farmington, Mo.</u> | | ADDRESS | |

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uterine Hemorrhage</u> | | | | | | | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u> | | | | | | | |
| | | DUE TO (c) _____ | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praeco Psychosis - - - - -</u> | | | | | | Abt. 20 yrs. | |

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|--|--|--|--|---|--|---|--|
| 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) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 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 Feb. 19, 1950, to Feb. 20, 1950, that I last saw the deceased alive on Feb. 20, 1950 and that death occurred at 12:10 A.M. from the causes and on the date stated above.

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|---|--|--|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) <u>John O. Brennan M.D.</u> | | 23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u> | | 23c. DATE SIGNED <u>2-28-50</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Feb. 22, 1950</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> | |

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|--|--|--|--|--|--|---------|--|
| DATE REC'D BY LOCAL REG. <u>Feb. 28, 1950</u> | | REGISTRAR'S SIGNATURE <u>Esther Rudloff</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. W. Clark, 1125 Hodiamont, St. Louis, Mo.</u> | | ADDRESS | |
|--|--|--|--|--|--|---------|--|

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

RECEIVED

MAR 6 1950

DISTRICT HEALTH OFFICE No. 4

File No. 350-314

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 _____

Licensed Embalmer No. 4084

P. O. Address Farmington, Md

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.