

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21916**
Registrar's No. **5691**

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).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Mo.	b. COUNTY
c. LENGTH OF STAY (In this place) 1 Wk.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Josephine Heitkamp		/d. STREET ADDRESS (If rural, give location) 7317 Pennsylvania	

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle)	c. (Last) Pleimann	4. DATE OF DEATH (Month) (Day) (Year) June 27 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 20 1892	9. AGE (In years last birthday) Months Days Hours Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? Mo.

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Edward
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE AND NAME Edward B. Pleimann	ADDRESS 7317 Pennsylvania
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>3 yrs.</u>
	ANTECEDENT CAUSES <u>Severe Arterio sclerosis</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.			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>No one</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>332X</u>
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22. I hereby certify that I attended the deceased from Jan 1947 to 6-27, 1950, that I last saw the deceased alive on 6-27, 1950, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>F. J. Swickhorby M.D.</u>	(Degree or title)	23b. ADDRESS <u>2528 S. Jefferson</u>	23c. DATE SIGNED <u>6-28-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 1 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JUN 30 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Parson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. P. Fendler Jr.</u>	ADDRESS <u>7128 Michigan</u>
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Clarence Rochow

Student Embalmer No.

Licensed Embalmer No. *3093*

P. O. Address *7178 Michigan*

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.