

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 13760
3423

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1007</u>		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) <u>61 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>2159</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4723 Ray Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Adolph P.W.</u> b. (Middle) _____ c. (Last) <u>Bartling</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 9th 1951</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 30, 1889</u>		9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 YEAR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Marcus Cem.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Adolph Bartling</u>			13b. MOTHER'S MAIDEN NAME <u>Carrie Schubert</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine Bartling</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>495-22-4251</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Carrie Bartling 4723 Ray Ave.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiac vascular disease</u> <u>8-10 Years</u> 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) _____			
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? <u>4421</u>			
22. I hereby certify that I attended the deceased from <u>12 Feb</u> , 19 <u>51</u> , to <u>9 April</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>9 April</u> , 19 <u>51</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Roy W. Schmeiner M.D.</u> (Degree or title)				23b. ADDRESS <u>6817 S. Groves Ave.</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - 11</u>		24b. DATE <u>Apr. 12, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Churchyard</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>APR 12 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Basator</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Blue Dwyer & Sons 2924 E. 20</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed Neville B. Frohwitter

Signed.....
Student Embalmer

Licensed Embalmer No. 3696

P. O. Address 500 W. 20th St.

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.