

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31551**  
Registrar's No. **8487**

FILED OCT 10 1951

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) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MADISON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS, MISSOURI</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>WOOD RIVER 8120</b>	
c. LENGTH OF STAY (in this place) <b>14 days</b>		d. STREET ADDRESS (If rural, give location) <b>LINCOLN ADDITION</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <b>BARNES HOSPITAL</b>			
3. NAME OF DECEASED a. (First) <b>EDGAR</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT. 20 1951</b>	
b. (Middle) <b>FILMORE</b>		c. (Last) <b>HERT</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. <input checked="" type="checkbox"/> NEVER MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-18-1894</b>
9. AGE (In years last birthday) <b>57</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	11. BIRTHPLACE (State or foreign country) <b>Mo. 0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
10a. <b>SELF EMPLOYED</b>	10b. KIND OF BUSINESS OR INDUSTRY		
13a. FATHER'S NAME <b>UNKNOWN</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>NELLIE HERT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>490-18-1758</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Clarence Hert</b> ADDRESS <b>EAST ALTON, ILLINOIS</b>	
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) <b>Friedlandia Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
ANTECEDENT CAUSES 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. <b>Pulmonary Emphysema</b> <b>3 wks</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>H90X</b>	
22. I hereby certify that I attended the deceased from <b>SEPT. 7, 1951</b> to <b>SEPT. 20, 1951</b> , that I last saw the deceased alive on <b>SEPT. 20, 1951</b> , and that death occurred at <b>4:30 p m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>S. B. Radu, M.D.</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>9-22-1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>VALHALLA MEMORIAL PARK</b>	24d. LOCATION (City, town, or county)* (State) <b>GODFREY, ILLINOIS.</b>
DATE REC'D BY LOCAL REG. <b>SEP 25 1951</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>RALPH GENT 2100 State Alton Ill</b>	

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

Call p. 17

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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 *Albert Mayfield* .....

Licensed Embalmer No. *3077* .....

P. O. Address *St. Louis Mo* .....

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.