No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39972

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10258

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST LOUIS Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. ANTHONY'S Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 17 ST. LOUIS 2179
d. STREET ADDRESS (If rural, give location) 2643 PENNSYLVANIA

3. NAME OF DECEASED (Type or Print) a. (First) PETER b. (Middle) A. c. (Last) BERNHARD

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7 1952

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH JULY 11 1866
9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY COFFEE MERCHANT
11. BIRTHPLACE (City and State or Foreign Country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ANTON BERNHARD
13b. MOTHER'S MAIDEN NAME MARY NIEDERHOFFER
14. NAME OF HUSBAND OR WIFE MAMIE BERNHARD (DEC'D

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME WALTER BERNHARD ADDRESS 2643 PENNSYLVANIA

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) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2½ days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerosis general — 2 years
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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 331X

22. *I hereby certify that I attended the deceased from* 11/4, 1952, *to* 11/7, 1952, *that I last saw the deceased alive on* 11/7, 1952, *and that death occurred at* 2:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] M.D.
23b. ADDRESS 3739 Gravois, St. Louis, Mo. (16)
23c. DATE SIGNED 11-7-52

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 4
24b. DATE Nov. 10 1952
24c. NAME OF CEMETERY OR CREMATORY S. S. PETER + PAUL
24d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

DATE REC'D BY LOCAL REG. NOV 7 1952
REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J. Budde

Licensed Embalmer No. 3989

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.