

FILED DEC 2 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40628

318

1003

Registrar's No. 10430

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY De Paul Hosp				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St, Louis		c. LENGTH OF STAY (If in place) 3 day		c. CITY (If outside corporate limits, write RURAL and give township) 2049 OR TOWN St, Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hosp.				d. STREET ADDRESS (If rural, give location) 1435 Hampton			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) _____		c. (Last) Rechtien		4. DATE OF DEATH (Month) (Day) (Year) 11-10-1952	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 8-15-1888	
9. AGE (In years last birthday) 64		10. UNDER 1 YEAR Months 2 Days 25		10. UNDER 2 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during last year, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) St, Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Anthony Bertel			13b. MOTHER'S MAIDEN NAME Anna Hilker			14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eleanor Ferguson 1435 Hampton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Hemorrhagic Pancreatitis ANTECEDENT CAUSES Chronic Cholecystitis DUE TO (b) Cholelithiasis DUE TO (c) Cholelithiasis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 584X			
22. I hereby certify that I attended the deceased from 11/5 , 19 52 , to 11/10 , 19 52 , that I last saw the deceased alive on 11/9 , 19 52 , and that death occurred at 3 AM m., from the causes and on the date stated above.							
23a. SIGNATURE (Deceased or title) Robert W. Staschuk, M.D.				23b. ADDRESS 508 N. GRAND AVE		23c. DATE SIGNED 11/12/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-13-1952		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. NOV 13 1952		REGISTRAR'S SIGNATURE J. C. Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WINGBERMUEHLE 3819 S Grand Blvd			

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. _____ Student Embalmer No. _____

Student
Student Embalmer

Signed George W. Kermelle

Licensed Embalmer No. 4611

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.