

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33671**  
8192

FILED SEP 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY			
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place)		e. STREET ADDRESS (If rural, give location) <b>3458 Williams Pl.</b>		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Faith Hospital</b>					
3. NAME OF DECEASED (Type or Print) <b>BERTHA</b>		a. (First) <b>J.</b>	b. (Middle)	c. (Last) <b>MAFFRAND</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 23 1953</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Nov. 6, 1885</b>	9. AGE (In years last birthday) <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <b>Henry Metz</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Masser</b>	14. NAME OF HUSBAND OR WIFE <b>Late Joseph W. Maffrand</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.	17. INFORMANT'S SIGNATURE OR NAME <b>Robert J. Webers</b> ADDRESS <b>3458 Williams Pl.</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia</b>		undeterm
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cancer ampule of Vater</b>		
DUE TO (c) <b>Operative trauma</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>Aug. 6; -53</b>

19a. DATE OF OPERATION <b>8-6-53</b>	19b. MAJOR FINDINGS OF OPERATION <b>C.A. 1st portion duodenum. Resection pylorus entire duodenum</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <b>152X</b>

22. I hereby certify that I attended the deceased from **Aug 1**, 19**53**, to **August 22, 1953**, that I last saw the deceased alive on **Aug 22**, 19**53**, and that death occurred at **8:45 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John S Young M.D.</b>	23b. ADDRESS <b>Mo. 1126 St. Louis Ave, St. Louis</b>	23c. DATE SIGNED <b>8-21-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug. 26, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Luth. Cem.</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		

DATE REC'D BY LOCAL REG. <b>AUG 24 1953</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl.</b>
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S.P. (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..

Student.....  
Signature of Student Embalmer

Signed *Richard W. Storvick*

Licensed Embalmer No. *4007*

P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.