

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24773**
Registrar's No. **7079**

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				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 township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST. LOUIS		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5617 SUTHERLAND				e. STREET ADDRESS (If rural, give location) 5617 SUTHERLAND			
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA b. (Middle) KANZLER c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) JULY 29 1954				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH DEC. 22 1864		9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME WILLIAM MILLER		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE FRED KANZLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS BEN BROEKER 5617 SUTHERLAND					
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) Nephritis, cystitis ANTECEDENT CAUSES Arteriosclerosis 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.					INTERVAL BETWEEN ONSET AND DEATH 6 wks ?	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					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? H:500			
22. I hereby certify that I attended the deceased from June 1, 1947 to July 29, 1954 , that I last saw the deceased alive on July 29, 1954 and that death occurred at 3:30 pm. , from the causes and on the date stated above.							
23a. SIGNATURE Dr. D. Johnson MD			23b. ADDRESS 6400 Maryland			23c. DATE SIGNED 7-29-54	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE JULY 31 1954	24c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		
DATE REC'D BY LOCAL REG. JUL 30 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Davis			

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 *Leo J. Budde*
Licensed Embalmer No. *398*
P. O. Address *St. Louis*

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.