

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

29125

State File No.

FILED SEP 2 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **7540**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7540			
I. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				e. STREET ADDRESS (If rural, give location) 5621 Botanical Ave 21390 13					
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA		b. (Middle) ****		c. (Last) NETTMANN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 14, 1954			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Nov. 21, 1871			
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Germany (Naturalized)			
11. BIRTHPLACE (City and State or Foreign Country) Germany (Naturalized)		12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Ignatz Schlageter		13b. MOTHER'S MAIDEN NAME Unknown			
13a. FATHER'S NAME Ignatz Schlageter		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Albrecht Nettmann		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Augusta Leimbach		ADDRESS 5621 Botanical Ave			
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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia. (cause undetermined)				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease with decompensation				3 days	
				DUE TO (c) Generalized Arteriosclerosis				10 days	
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				?	
19a. DATE OF OPERATION 8/2/54		19b. MAJOR FINDINGS OF OPERATION Cataract removal				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) _____		4200			
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 _____					
22. I hereby certify that I attended the deceased from Aug. 11, 1954 , to Aug. 14, 1954 , that I last saw the deceased alive on Aug. 11, 1954 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE [Signature] (Degree or title) M.D.				23b. ADDRESS 634 N. Grand Blvd.		23c. DATE SIGNED 8-16-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 8-16-54		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. AUG 16 1954		REGISTRAR'S SIGNATURE J. Paul Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.					

S.P. (Licensed Embellisher's Statement on Reverse Side)

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

No. 300
10-48

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 *William B. White*.....

Licensed Embalmer No. *429*

P. O. Address *5228 Lehigh*

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.