

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31996**
Registrar's No. **8213**

FILED SEP 21 1954

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8213	
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) St. Louis		c. LENGTH OF STAY (In this place) 2 wks		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 St. John's Hospital				e. STREET ADDRESS (If rural, give location) 7 4746 Carter Avenue 2079			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
Sister M. Herlinda S.S.N.D. (Margaret Maerz)						4. DATE OF DEATH 9 - 5 - 1954	
5. SEX Fem		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 7 - 27 - 1890	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (City and State or Foreign Country) Iowa	
11. BIRTHPLACE (City and State or Foreign Country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Maerz		13b. MOTHER'S MAIDEN NAME Mary C. Eiberger	
13a. FATHER'S NAME John Maerz		13b. MOTHER'S MAIDEN NAME Mary C. Eiberger		14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Sister M. Rene		ADDRESS 4746 Carter Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) My per tension caused vascular disease				INTERVAL BETWEEN AND DEATH 4hr			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral vascular accident			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		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? 443x			
22. I hereby certify that I attended the deceased from Aug 27, 1954 to Sept 5, 1954 , that I last saw the deceased alive on 9/7 , 19 54 , and that death occurred at 7:50 Am. , from the causes and on the date stated above.							
23a. SIGNATURE Thorwald				23b. ADDRESS 408 Humboldt Blvd		23c. DATE SIGNED 9/7/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/8/54		24c. NAME OF CEMETERY OR CREMATORY Villa Gesu Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL SEP 7 1954		REGISTRAR'S SIGNATURE J. Earl Smith, md.		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral		ADDRESS 1905 Union Blvd.	

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

Dr. Chas Miller
Humbolt Bldg. 10 - 3

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 *Warren A. Carver*.....
Licensed Embalmer No. *35*.....

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.