

No. 300
10.48
FILED SEP 29 1955THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 30588
Registrar's No. 7601

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 30588		Registrar's No. 7601					
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. 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 Lutheran Hospital				e. STREET ADDRESS (If rural, give location) 3122 Clifton Ave., 20090		3							
3. NAME OF DECEASED (Type or Print) Olivia Berra			a. (First)		b. (Middle)		c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Aug. 30, 1955			
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Oct. 30, 1917		9. AGE (In years last birthday) 37		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Joseph Baccala			13b. MOTHER'S MAIDEN NAME Maria De Filippo			14. NAME OF HUSBAND OR WIFE John Berra							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. unk.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Berra 3122 Clifton								
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) Cancer of ovary - metastatic ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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	
19a. DATE OF OPERATION 6-9-55		19b. MAJOR FINDINGS OF OPERATION Cancer of ovary.						175X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) m		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) m.		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 6, 1951, to Aug 30, 1955, that I last saw the deceased alive on Aug 29, 1951, and that death occurred at 5352 m., from the causes and on the date stated above.													
23a. SIGNATURE R. Berg MD (Degree or title)				23b. ADDRESS 3203 S. Grand				23c. DATE SIGNED 8.30.55					
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9-1-55		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.							
DATE REC'D BY LOCAL REG. AUG 30 1955		REGISTRAR'S SIGNATURE Carl Smith MD			FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo.								

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Ralph Berg
3203 S. Grand Blvd.,
1130 to 3 p.m

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..... *David Van Johnson*

Licensed Embalmer No. *429*

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.