

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38015**
Registrar's No. **10105**

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

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	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) 3823 Dover Place	

3. NAME OF DECEASED (Type or Print) Mary Berring			4. DATE OF DEATH (Month) (Day) (Year) Nov 19 1955		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 23 1882	9. AGE (In years last birthday) 75 72	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 _____		11. BIRTHPLACE (City and State or Foreign Country) Jugoslavia		12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Albert Schriener	13b. MOTHER'S MAIDEN NAME Mary Buchbaum	14. NAME OF HUSBAND OR WIFE Nicholas
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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 Nicholas Berring	ADDRESS 3823 Dover Place
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		DUE TO (b) Arterio-sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION As above		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21. ACCIDENT OR SUICIDE OR 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) _____	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. 18 55, to Nov. 19 1955, that I last saw the deceased alive on Nov. 18 1955, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) W. W. Eades M.D.	23b. ADDRESS 7602 So. Broadway	23c. DATE SIGNED 11/19/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/21/55	24c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem	24d. LOCATION (City, town, or county) (State) St Louis Missouri
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DATE REC'D BY LOCAL REG. NOV 21 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home	ADDRESS 1926 Allen Av
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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.....
Ronald K. Lehman

Licensed Embalmer No. *339*

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.