

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10433

FILED APR 2 1956

State File No. 10433
Registrar's No. 2795

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 10433		Registrar's No. 2795					
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 town(ship)) 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 St. Louis State Hospital				e. STREET ADDRESS (If rural, give location) 13 5100 Arsenal Street									
3. NAME OF DECEASED (Type or Print) Lillian Annabelle Berwanger			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) March 2 1956				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH 11-24-68		9. AGE (In years last birthday) 87		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) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Fredericksburg, Indiana				12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Theodore Berwanger				13b. MOTHER'S MAIDEN NAME Mary Frances Snarr				14. NAME OF HUSBAND OR WIFE unknown					
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. N. Morris, State Hospital							
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia 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. Senility, cachexia						INTERVAL BETWEEN ONSET AND DEATH 3 days			
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) 491x									
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 June 4 , 19 48 , to March 2 , 19 56 , that I last saw the deceased alive on March 2 , 19 56 , and that death occurred at 11:15 a.m. , from the causes and on the date stated above.													
23a. SIGNATURE Carl Henry K. Bundy, M.D. (Degree or title)				23b. ADDRESS 5100 Arsenal Street				23c. DATE SIGNED 3-2-56					
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3-19-56		24c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.							
DATE REC'D BY LOCAL REG. MAR 19 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker, 4104 Manchester							

(Licensed Embalmer's Statement on Reverse Side)

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

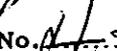
300
48

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 .....

Licensed Embalmer No. 

P. O. Address..... 

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (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.