

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18444

STATE FILE NUMBER

FILED JUN 7 1957

318

1003

5014

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <input checked="" type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 4719 Wilcox Ave.</u>		Length of stay in lb <u>2 15</u>	STREET ADDRESS (If outside, give location) <u>4719 Wilcox Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle _____ Last <u>BERNS</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1875</u>		9. AGE (In years last birthday) <u>82</u> 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) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Alsace Lorraine, France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Ring</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Verna Berns</u> Address <u>4719 Wilcox Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> <u>Arteria Sclerotic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 or 3 hrs</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>April 5-57</u> to <u>May 27-57</u> and last saw her alive on <u>May 25</u> . Death occurred at <u>5:16 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Marilyn J. Stover M.D.</u>				22b. ADDRESS <u>1508 Olive St.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 29, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 28 '57</u>		25. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare and Public Service  
300-1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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. *28*

P. O. Address *928 W. King St.*

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.