

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 9 - 1957

STATE FILE NUMBER

41740

10733

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis			c. CITY OR TOWN Mehlville 4600 ₂		St Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Anthony Hosp			Length of stay in lb 7 Days		d. STREET ADDRESS Rt 9 Box 579
3. NAME OF DECEASED (Type or print) First Middle Last Amanda Lena Berger			4. DATE OF DEATH Month Day Year Nov 8th 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7 1873	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days 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 country) St Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Julius Beiter			14. MOTHER'S MAIDEN NAME Mary Burk		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr Herman M Berger Mehlville Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis					INTERVAL BETWEEN ONSET AND DEATH 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease					10 yrs.
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 420.0					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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- Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from June 1957 to Nov. 8 1957 and last saw her alive on 7-8-57 Death occurred at 11:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert W. Tichauer MD			22b. ADDRESS Rt. 9 Box 579 Mehlville Mo		22c. DATE SIGNED 11-9-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 11 1957	23c. NAME OF CEMETERY OR CREMATORY Assumption Cem.		23d. LOCATION (City, town, or county) (State) Mattese, Mo.	
24. FUNERAL DIRECTOR Fey Funeral Home Mehlville Mo.		25. DATE RECD. BY LOCAL REG. NOV 12 '57		26. REGISTRAR'S SIGNATURE J. Paul Smith MD M. J. B.	

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 *Stanley H. Dixon*
Licensed Embalmer No. *419*

P. O. Address *H. L.*

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.