

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002907
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8

300
-57
38
093
3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospital		d. STREET (If outside, give location) ADDRESS 5118 N. Broadway (7)	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA E. ENGLAND		4. DATE OF DEATH Month Day Year January 1, 1959	
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) White Springs, Tennessee
13a. FATHER'S NAME Unknown Beckner		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Divorced
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. Unknown	17. INFORMANT Address Mildred Trueb 5118 N. Broadway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Nephrosis</i> DUE TO (b) <i>Arterio Sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>JOS. M. QUINN</i> (Degree or title) 3 <i>son in law of deceased</i>	
22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>1/2/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 5, 1959	23c. NAME OF CERETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County MO.
24. FUNERAL DIRECTOR ADDRESS SUEDMYER & SON'S 3934 N. 20th Street		25. DATE RECD. BY LOCAL REG. JAN 2 '59	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith mo</i> T.H.T.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *W E Morris*

Licensed Embalmer No. *3360*
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.