THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-003687
STATE FILE NUMBER

RECD FEB 10 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 313

**1. PLACE OF DEATH**
a. COUNTY St. Louis
b. CITY OR TOWN Clayton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) County Hospital — Length of stay in Ib 46days

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Affton 4810 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 7900 LaBelle — Reside on Farm Yes [ ] No [X]

**3. NAME OF DECEASED** (Type or print): First Mary — Middle — Last Bergauer

**4. DATE OF DEATH** Month 1 Day 31 Year 59

**5. SEX** Female

**6. COLOR OR RACE** White

**7. MARRIED** [ ] **NEVER MARRIED** [ ] **WIDOWED** [ ] 3 **DIVORCED** [X]

**8. DATE OF BIRTH** July 5,1903

**9. AGE** (In years last birthday) 55 — 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** Home

**11. BIRTHPLACE** (City and state or country) Europe 8

**12. CITIZEN OF WHAT COUNTRY?** USA

**13a. FATHER'S NAME** John Frisch

**13b. MOTHER'S MAIDEN NAME** Not Known

**14. NAME OF HUSBAND OR WIFE** None

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) No (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.** Unk.

**17. INFORMANT** Charles Bergauer Address 7900 LaBelle

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of gall bladder with
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) widespread metastasis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1551

INTERVAL BETWEEN ONSET AND DEATH

**19. WAS AUTOPSY PERFORMED?** YES [ ] NO [ ] 0

**20a. ACCIDENT** [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

**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. Month, Day, Year

**20d. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

**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 12-16-58 to 1-31-59 and last saw her/him alive on 1-31-59
Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

**22a. SIGNATURE** (Degree or title) Emil L. Martini M.D. 0

**22b. ADDRESS** 601 So. Brentwood

**22c. DATE SIGNED** 2-1-59

**23a. BURIAL, CREMATION, REMOVAL** (Specify) BURIAL

**23b. DATE** 2/4/59

**23c. NAME OF CEMETERY OR CREMATORY** RESURRECTION

**23d. LOCATION** (City, town, or county) (State) ST.LOUIS CO. MO.

**24. FUNERAL DIRECTOR** J.L.ZEIGENHEIN & SONS **ADDRESS** 7027 GRAVOIS

**25. DATE RECD. BY LOCAL REG.** 2-2-59

**26. REGISTRAR'S SIGNATURE** John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Donald E Bing

Licensed Embalmer No. 4863

P. O. Address 7027 Grove

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.