

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**59-015314**

STATE FILE NUMBER

**2 3967**

Health,  
Welfare  
Public  
Service

2/29/4  
300 d  
1-56

All diseases in Part I must be casually 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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>4615 Lindell</b> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle Last <b>LEVY</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/1890</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b>170x</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Management</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Sievers</b>	
14. MOTHER'S MAIDEN NAME <b>Sppia Koeln</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Goldman Jr.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN METASTASIS</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CANCER of BREAST</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)			INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <b>12-18-58</b> to <b>Apr. 21, 1959</b> and last saw her <del>him</del> alive on <b>Apr. 21, 1959</b> Death occurred at <b>1:15 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Margaret E. Leven</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>100 N. Euclid</b>	
22c. DATE SIGNED <b>4/21/59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>Apr. 24, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Mausoleum</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		24. FUNERAL DIRECTOR <b>Ambruster Mortuary, 6633 Clayton Rd.</b> ADDRESS	
25. DATE RECD. BY LOCAL REG. <b>APR 22 '59</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

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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.....  
*Arvid J. Larsson*

Licensed Embalmer No. *477*

P. O. Address *H. Larsson*

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.