

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
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U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH **59-038080**
FILED VS OCT 23 1959 **2 9509**
 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>55 Yrs.</u>	c. CITY OR TOWN <u>St. Louis 9,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deconess Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7015 Marquette Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MRS. BERNICE</u> Middle <u>EILEEN</u> Last <u>SILBER</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>15,</u> Year <u>1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/1904</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk Traffic Div. SW Bell Telephone</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis Mo.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Michael Maurer</u>		13b. MOTHER'S MAIDEN NAME <u>Gertrude Brennan</u>		14. NAME OF HUSBAND OR WIFE <u>Merle G Silber</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>	16. SOCIAL SECURITY NO. <u>488-10-4395</u>	17. INFORMANT <u>Merle G. Silber</u>	Address <u>7015 Marquette Ave. (9)</u>
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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>Carcinoma, rt. breast.</u> <u>with widespread metastases</u> DUE TO (b) _____ DUE TO (c) <u>170x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____	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
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21. I attended the deceased from Jan 28, 1957 to Oct 15, 1959 and last saw her Oct. 14, 1959 alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Bertile Eck M.D.</u> (Degree or title)	22b. ADDRESS <u>950 Francis Place</u>	22c. DATE SIGNED <u>10/16/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/17/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hiram Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Alexander & Sons, Inc 6175 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 16 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Birkle Eck
950 Francis Pl.
PA. 6 2828

Friday 9:30 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6171200

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.