

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 11 1960

-60-003803

2 388

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

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		Length of stay in 1b 1 day	c. CITY OR TOWN Bridgeton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 12037 Old St Charles Reside on Farm No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Last or print) Bertha J Merk			4. DATE OF DEATH Month Jan Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1871	9. AGE (last birthday) 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Gasconade Co Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Koepke		13b. MOTHER'S MAIDEN NAME Augusta Barlish	14. NAME OF HUSBAND OR WIFE Henry Merk	
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. None	17. INFORMANT Ellinor John Bridgeton Mo Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Aspiration of vomitus			immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) gastric dilatation		1 hour
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Vascular thromboses and Pulmonary emboli Fracture of femur (intracapsular)		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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) It fell & sustained fx of hip
20c. TIME OF INJURY Hour 12 Month, Day, Year 28 1959 a.m. p.m.		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 35 Home	20f. CITY, TOWN, OR LOCATION Bridgeton	COUNTY St. Louis Mo.	STATE
21. I attended the deceased from 8-60 to 1-10-60 and last saw her alive on 1-9-60 (Date of death)		Death occurred at 11:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Chelly B. Varenan M.D.	22b. ADDRESS 216 S. Kingshighway St Louis 1-11-60	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1.14.60	23c. NAME OF CEMETERY OR CREMATORY Westenkuehler
23d. LOCATION (City, town, of county) St Charles Mo		(State)

24. FUNERAL DIRECTOR Arthur C Baue Funeral Home	ADDRESS St Charles Mo	25. DATE RECD. BY LOCAL REG. JAN 12 1960	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 William C. Jones

Licensed Embalmer No. 3144

P. O. Address 1806 Under

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.