

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016921

FILED VS. MAY 6 1960

2 4533

STATE FILE NUMBER

DEED

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		c. CITY OR TOWN <u>ST. Louis</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>Marion Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2843 Salome ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Ellen</u> Last <u>Herget</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1928</u>		9. AGE (last birthday) <u>72</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Fred Wohlschlaeger</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Allgeyer</u>			14. NAME OF HUSBAND OR WIFE <u>Herbert Herget</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>None</u>		17. INFORMANT <u>Otto Wohlschlaeger</u>			Address <u>512 Dresden</u>	
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>ABDOMINAL CARCINOMATOSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ADENOCARCINOMA OF SIGMOID</u>							<u>8 mo.</u>		
DUE TO (c) <u>153.3</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.)					
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	
21. I attended the deceased from <u>12-15-59</u> to <u>4-27-60</u> and last saw her <u>live</u> on <u>4-27-60</u> . Death occurred at <u>5:35</u> <u>p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>O. Jones</u> (Degree or title) <u>MD</u>			22b. ADDRESS <u>3616 S. Beverly St. Louis</u>			22c. DATE SIGNED <u>4-28-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew's Cemetery</u>		23d. LOCATION (City, town, or county) <u>ST. Louis, Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>Witt Bros L. &amp; H. G. 2929 S. Jefferson</u>			25. DATE RECD. BY LOCAL REG. <u>APR 28 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stanley H. Dixon  
Licensed Embalmer No. 419

P. O. Address H. L.

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.