RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEC 21 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11936 —60—047597 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Flower Con. Home — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) 4423 Delor St — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BERTHA		ILLERT	12-10-1960		

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HR Hours / Min.
Female	White		2-23-1869	91 Yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
At Home		St. Louis Mo	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Louis Zepp	Mary Wagner	William E. Illert Dece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		None	Mary Warner	4424 Delor St

MEDICAL CERTIFICATION

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)	Cerebral Vascular Accident	1 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	?
DUE TO (c)	331x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Bronchiectasis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	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 November '60 Dec '60 and last saw her alive on 12/8/60

Death occurred at 9:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
M. Cecilia Reichert MD	16 Hampton Village St.	12/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	12-13-1960	New St. Marcus Cemetery	7901 Gravois Ave	Mo

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Ziegenhein Brothers	6409 Gravois Av	DEC 13 1960	Earl Smith, M.D.

DOCUMENT

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 Herbert J. Gau Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22

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