

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1334

FILED VS FEB 20 1961

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5617 Enright Ave</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5617 Enright</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>R.</u> Last <u>Hartmann</u>						4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>61</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>W.</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>12/13/73</u>		9. AGE (last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Jacob Rosenberg</u>				13b. MOTHER'S MAIDEN NAME <u>Bertha Haas</u>				14. NAME OF HUSBAND OR WIFE <u>Dr. Jacob Hartmann (Dec'd)</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 Address <u>Mrs. Edward Stillman 449 N. Hanley</u>					
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) <u>Head injury, accidental</u>										<u>60 hours</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (b) <u>Generalized arteriosclerosis</u>										<u>904.0-21</u>	
DUE TO (c) <u>Diabetes mellitus</u>										<u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2-6-61</u>										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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell at home on way to bathroom</u>							
20c. TIME OF INJURY Hour <u>1</u> a.m. <u>PM</u> Month, Day, Year <u>2-6-61</u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis,</u>		COUNTY <u>Mo.</u>		STATE	
21. I attended the deceased from <u>November 15, 1945</u> to <u>February 8, 1961</u> and last saw her alive on <u>February 8, 1961</u> Death occurred at <u>1:20 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Deceased or title) <u>[Signature]</u>						22b. ADDRESS <u>3720 Washington Blvd., St. Louis 8</u>			22c. DATE SIGNED <u>2/9/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>2/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai</u>			23d. LOCATION (City, town, or county) (State) <u>8400 Gravois Ave</u>				
24. FUNERAL DIRECTOR <u>Mayer</u> ADDRESS <u>4356 Lindell Blvd</u>					25. DATE RECD. BY LOCAL REG. <u>FEB 9 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>				

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

Stanley A. Ripon

Licensed Embalmer No. *24190*

P. O. Address, *S. L.*

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.