

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045153

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 375V

FILED NOV 26 1962

VS 300
Rev. 4/59

14000

2 2/3

3

4 0

5 2

6

7 0

8 2

9

10

11

12 86-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

SHOULD READ

ITEM NO.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis County</u>		a. STATE <u>Missouri</u> COUNTY		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>Bella Villa Nursing</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2907 S Kingshighway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX	
First <u>Frank</u> Middle <u>F</u> Last <u>Berthold</u>			Month <u>Nov</u> Day <u>5</u> Year <u>1962</u>			Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>	
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>3/12/07</u>		9. AGE (last birthday) <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Mover</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Moving</u>		11. BIRTHPLACE (City and state or country) <u>Fenton Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>Charles Berthold</u>			13b. MOTHER'S MAIDEN NAME <u>Ida Nolan</u>			14. NAME OF HUSBAND OR WIFE <u>Lillian (Deceased)</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.		17. INFORMANT <u>Ida Levleit 11609 Larimore Rd</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome associated to Syphilitic Central Nervous System (Sherrington-Vascular)</u>							
DUE TO (b) <u>026 X</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 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.) <u>NONE</u>					
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>May 1962</u> to <u>11-5-62</u> and last saw him alive on <u>10-30-62</u>							
Death occurred at <u>12¹⁰ P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Allen Dr. Nearney M.D.</u>			22b. ADDRESS <u>860 N. Woodlawn</u>			22c. DATE SIGNED <u>11-7-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11/8/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Picker Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Missouri</u>	
24. FUNERAL DIRECTOR <u>Moydell Funeral Home 1926 Allen</u>			25. DATE RECD. BY LOCAL REG. <u>11-7-62</u>		26. REGISTRAR'S SIGNATURE <u>John M. Murphy 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 Wadley F. Juelley
Licensed Embalmer No. 9950

P. O. Address St. Louis

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.