

JAN 2 1940 791
Registration District No. _____

Primary Registration District No. _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH: **003**
(a) County _____
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution: **City Hospital, #1**
(d) Length of stay: In hospital or institution **1 Mo. 5 Days**
In this community _____
years, months or days

3. (a) PRINT FULL NAME: **John Alder - 436**
8. (b) If veteran, name war: **No** 3. (c) Social Security No. **No one**

4. Sex: **male** 5. Color or race: **white** 6. (a) Single, widowed, married, divorced, **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Feb., 8, 1882**
(Month) (Day) (Year)

8. AGE: Years **67** Months **9** Days **22** If less than one day _____ hr. _____ min.

9. Birthplace: **New Haven Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation: **gardner**

11. Industry or business: **self**

12. Name: **Charles J. Alder**

13. Birthplace: **New Haven Mo**
(City, town, or county) (State or foreign country)

14. Maiden name: **Augusta Bergendoff**

15. Birthplace: **Herman Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: **Jerry Sweet**

(b) Address: **609 Sunnyside, Webster Groves**

17. (a) **Burial** (b) Date thereof: **Dec. 9, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **NEW HAVEN, Mo.**

18. (a) Signature of funeral director: **John L. Juegenheim**
(b) Address: **7027 Grand Ave.**

19. (a) **DEC 8 1939** (b) **J. D. [Signature]**
(If received local registrar) (If received local registrar)

2. USUAL RESIDENCE OF DECEASED:
Mo 1
(a) State: _____ (b) County: _____
(c) City or town: **Webster Groves NR**
(d) Street No.: **609 Sunnyside**
(e) If foreign born, how long in U. S. A.: _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **7**, year **1939** hour **7:55** minute **A.** M.
21. I hereby certify that I attended the deceased from **November 2**, 19 **39** to **December 7**, 19 **39**
that I last saw him alive on **December 7**, 19 **39** and that death occurred on the date and hour stated above.

Immediate cause of death: **Acute Depressive Psychosis Preliminary Tuberculosis**
Due to _____
Due to _____

Other conditions: **AS**
(Include pregnancy within 3 months of death)
Major findings: **AS**
Of operations: _____
Of autopsy: _____

PHYSICIAN: _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury: _____
23. Signature: **J. D. [Signature]** (M. D. or other) **MD**
Address: **1515 Lafayette** Date signed: **12/7/39**

FORM 1007-EM-10-11

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

41383
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township St Louis Primary Registration District No. 1003
(c) City St Louis (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 10506

2. PRINT FULL NAME

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

John Alder

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 7, 1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF OK

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 8 1882

I last saw h. alive on 19..... to 19..... Death is said to have occurred on the date stated above, at..... m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 67 9 22

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

Other contributory causes of importance:
Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS).....

20. FILED 29-16-40 19..... J. B. Budach Local Registrar.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify..... (Signed) J. S. Laffayette, M. D.
(Address) 15-15 Lafayette

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

