

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11944

State File No. _____

APR 9 1941
Registration District No. 84

Primary Registration District No. 101

Registrar's No. 638

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 25 years

3. (a) PRINT FULL NAME Josephine Alsop

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife FRANK ALSOP

6. (c) Age of husband or wife if alive UNKNOWN

7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years about 63 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace ST LOUIS MO D
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business AT HOME

MOTHER FATHER

12. Name UNKNOWN

13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. M. Spath

(b) Address 5041 - IDAHO ST LOUIS MO

17. (a) BURIAL (b) Date thereof 3-22-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST TRINITY LUTH.

18. (a) Signature of funeral director BAWMANN BROTHERS

(b) Address OVERLAND MO

19. (a) MAR 23 1941 (b) Overmann
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS

(c) City or town WELLSTON
(If outside city or town limits, write "RURAL")

(d) Street No. 6416 - St Louis
(If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 22 year 1941 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from 3-17-41 to 3-22-41 that I last saw her alive on 3-22-41 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis

Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: 8301

Of operations _____

Of autopsy _____

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 B. H. Steinhilber (M. D. or other) _____

Address ST LOUIS CO HOSPITAL Date signed 3-22-41

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 *E. J. Allen*

Licensed Embalmer No. *3501*

P. O. Address *Overland mo*

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, fact should be so stated above.