

FILED MAR 13 1944

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo**
(b) City or town **St. Louis, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL")
(d) Street No. **6245 San Boita**
(If rural, give location) **5**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Edith Alderson**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, widowed **2 divorced, widowed**
6. (b) Name of husband or wife **EAGAR** 6. (c) Age of husband or wife if alive **Now** years **18**
7. Birth date of deceased **Now** (Month) **18** (Day) **1875** (Year)

8. AGE: Years **68** Months **3** Days **15** If less than one day hr. min.

9. Birthplace **Montgomery City Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **GUSTAVE ITTNER**
13. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **MARY KRAFT**
15. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Clara King**
(b) Address **2203 Blendon Pl.**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **3 5 44**
(Month) (Day) (Year)
(c) Place: burial or cremation **Wellsville Mo**

18. (a) Signature of funeral director **Howland Mortuary**
(b) Address **4355 Washington**

19. (a) **MAR 3 1944** (Date received local registrar) (b) **J. J. Bredect** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **2**
year **1944** hour **3 25** minute **A.M.**
21. I hereby certify that I attended the deceased from **Mar 1**, 19**44**, to **Mar 2**, 19**44**
that I last saw h. **alive on Mar 2**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy causing paralysis**
Due to **Hypertension**
Due to **82**
Other conditions (Include pregnancy within 3 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

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) (c) Means of injury **3**
23. Signature **R. Berg** (M. D. or other)
Address **253 White** Date signed **3/3/44**

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

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 John Ketter

Licensed Embalmer No. 3880

P. O. Address St Louis, 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.