

FILED OCT 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29852

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8471

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home of the Friendless 4431 S. Broadway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 yrs. 5 1 1/2 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4431 S. Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. ALBA RHODES

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 widow

6. (b) Name of husband or wife Albert Rhodes 6. (c) Age of husband or wife if alive 1857 years

7. Birth date of deceased February 17 1857
(Month) (Day) (Year)

8. AGE: 87 Years 7 Months 17 Days If less than one day hr. min.

9. Birthplace St. Louis Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Stacy

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

14. Maiden name Virginia Stacy

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

16. (a) Informant Mrs. M. Jones

(b) Address 4431 S. Broadway

17. (a) Burial (b) Date thereof October 6, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) OCT 5 1944 (Date received local registrar)

J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11
year 1944 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from October 19 33 to Oct 4 44
that I last saw alive on Oct 2 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction
Chronic Myocarditis

Due to Bronchial asthma

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations no

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 Photo Physician (M. D. or other) MD
Address 3750 Washington Date signed 10/4/44

Duration

3 weeks
3 yrs

3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Louis C. Hoffmeister Registered Apprentice No.
working under my personal supervision.

Signed Louis C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.