

FILED NOV 31 1944

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 9853

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: Mo Baptist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME Adolph C. Albrecht

3. (b) If veteran, name war no. 3. (c) Social Security No. 526-01-441

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Carrie Albrecht 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 21 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Belleville Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Stock Room Manager

11. Industry or business Albrecht-Burke Inc.

MOTHER FATHER { 12. Name Charles Albrecht
13. Birthplace Belleville Ill. (City, town, or county) (State or foreign country)
14. Maiden name Sara Mueller
15. Birthplace Crestaline Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Irvin O. Albrecht

(b) Address 421 E. Bodley Av. Kirkwood

17. (a) Burial (b) Date thereof 11-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cen

18. (a) Signature of funeral director With Bro. L. H. K.

(b) Address 2929 S Jefferson Av

19. (a) NOV 21 1944 (b) J. F. Bredebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL") 199
(d) Street No. 4040 Olive St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1944 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from NOV 16 1944 to NOV 19 1944
that I last saw him alive on NOV 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart

Due to Chronic myocarditis - Coronary sclerosis

Due to Intestinal obstruction {Strangulated femoral hernia} 4 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Strangulated femoral hernia, intestinal obstruction
Of operations _____
Of autopsy Coronary sclerosis, myocarditis

Duration

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 Delbert Steffen (M. D. or other) _____
Address 4500 Olive Date signed 11/20/44

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.....

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

Signed.....*Edgar F. Witt*.....

Licensed Embalmer No. *2107*.....

P. O. Address. *2929 S. Jefferson*.....

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.