

No. 2
M-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

4180

STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 101

FILED JAN 21 1946

Registration District No.

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Manchester Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Franklin 36
(c) City or town Robertsville, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Ulbricht

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Late Emilie Julius Ulbricht 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 31 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 2 8 hr. min.

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

10. Usual occupation Stone Mason (Retired since 1928)

11. Industry or business _____
12. Name Unknown Ulbricht
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C.D. Kronsbein
(b) Address 5872 Cates Ave.

17. (a) Cremation (b) Date thereof 1-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Chapel
18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. & Concordia Lane

19. (a) 1/7/46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8th
year 1946 hour 8:30 minute P.M. M.

21. I hereby certify that I attended the deceased from Nov 26
1945 to Jan 8, 1946
that I last saw him alive on Jan 7, 1946
and that death occurred on the day and hour stated above.

Immediate cause of death cerebral hemorrhage
emboly
Due to generalized arteriosclerosis
830

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

Major findings:
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?

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature A. J. Merklin M.D. (M. D. or other)
Address 3507 Potomac Date signed 1-9-46

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

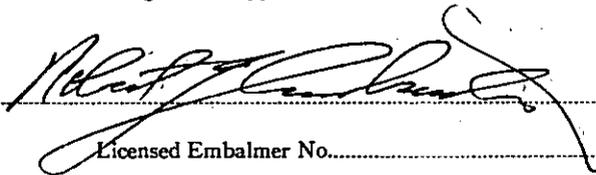
2199

MAY 6 1948

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, fact should be so stated above.