

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE - - - THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

31505

State File No.

FILED SEP 30 1946
318

Primary Registration District No. 1003

Registrar's No. 8123

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:
Christian Hospital
(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

3. (a) PRINT FULL NAME Marilyn Louise Alfermann

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased May 29 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

9 3 20 hr. min.

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

10. Usual occupation Child

MOTHER FATHER

11. Industry or business _____

12. Name Cornelius Alfermann

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

14. Maiden name Gertrude Hoelscher

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

16. (a) Informant Mrs. Gertrude Alfermann

(b) Address Krakow, Mo.

17. (a) Burial (b) Date thereof 9-21-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Krakow, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 20 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1946 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from 9-18-1946 to 9-19-1946
that I last saw her alive on 9-18-1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute Cardiac Decompensation

Due to Acute Toxemia
Generalized Peritonitis

Due to Pelvic Abscess Left
Perforated Acute Appendicitis

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

Major findings: Perforated Acute Appendicitis

Of operations: Generalized Peritonitis

Of autopsy: Abscess Left Subphrenic

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) None

(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 0

23. Signature Nicholas J. Stale (M. D. or other) M.D.

Address 3861 St. Louis Ave. Date signed 9/19/46

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

30000

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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.....

J. W. Wilkinson

Licensed Embalmer No.....

3575

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.