

S. No. 2  
1-12-45  
7. 5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 10480  
Registrar's No. 2845

Registration District No. 318

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
6525 Minnesota Ave., /  
(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 Soledad Alvarez

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 Married

6. (b) Name of husband or wife Thomas Alvarez

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 22, 1894  
(Month) (Day) (Year)

8. AGE: Years Months 23 Days 23

53 0 ~~22~~

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Spain 5  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Jose Alvarez

13. Birthplace Spain 5  
(City, town, or county) (State or foreign country)

14. Maiden name Spain 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Thos. Alvarez

(b) Address 6525 Minnesota

17. (a) Burial (b) Date thereof 3-18-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Southern Funeral Home

(b) Address 6322 S. Grand Blvd.

19. (a) MAR 18 1947 J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County and

(c) City or town St. Louis 117  
(If outside city or town limits, write "RURAL")

(d) Street No. 6525 Minnesota Ave., 9  
(If rural, give location) 10

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15,  
year 1947 hour 10 p.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Aug  
10, 1947, to March 15, 1947  
that I last saw him alive on March 15, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Permeant Anemia 20 yrs.  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)  
(e) Means of injury \_\_\_\_\_

23. Signature May Stahlhoff (M. D. or other) MD

Address 512 Olive St Date signed 3/17/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... *Albert Mayfield* .....  
Licensed Embalmer No..... *3077* .....  
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.**