

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED APR 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

138155
State File No. _____
Registrar's No. 3499

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3499

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 hours
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Albert Thomas Ambus
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race COL
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MILDRED AMBUS 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased MAY 12 1916
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
31 10 27 hr. _____ min. _____

9. Birthplace ARK. 1
(City, town, or county) (State or foreign country)

10. Usual occupation LAGOR.

11. Industry or business _____

MOTHER FATHER
12. Name JACK AMBUS
13. Birthplace ARK. 1
(City, town, or county) (State or foreign country)
14. Maiden name LOUISE PETERSON
15. Birthplace ARK. 1
(City, town, or county) (State or foreign country)

16. (a) Informant MILDRED AMBUS
(b) Address 2921 FRANKLIN

17. (a) BURIAL (b) Date thereof 4-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FATHER Dickerson

18. (a) Signature of funeral director F. A. GREEN

(b) Address 4214 DELMAR BLVD

19. (a) APR 12 1948 (Date received local certificate)
J. J. Braker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County and
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2921 Franklin
21 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 9
year 1948 hour 5 minute 15 a. M.
21. I hereby certify that I attended the deceased from April 8, 1948, to April 9, 1948
that I last saw him alive on April 9, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage
Duration Undet.

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy No
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 0

23. Signature Isaac Daniels (M. D. or other) _____
Address 2601 N Whittier Date signed 4/9/48

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.....

Rayton V. Swan, Registered Apprentice No. *101*
working under my personal supervision.

Signed *J. A. Heen*.....

Licensed Embalmer No. *2963*.....

P. O. Address *4214 DELMAR BLVD*.....

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.