

318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 12354  
5125  
Registrar's No.

Registration District No. Primary Registration District No.

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

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: Enroute City Hospital 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Oscar William Altmeyer  
(b) If veteran, name war World War I  
(c) Social Security No. 499-05-6702

4. Sex Male D 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive Unk. years  
7. Birth date of deceased September 20 1886  
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation Concrete Worker

11. Industry or business

MOTHER FATHER

12. Name Unknown 9  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown 11  
15. Birthplace Unknown 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Scherberg  
(b) Address # 37 Fair Oaks Lodge  
17. (a) Burial (b) Date thereof 6-4-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
J. T. Bredius  
19. (a) JUN 3 1948 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 100  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 112 So. 4th St. 9  
(If rural, give location)  
(e) Citizen of foreign country? 25 (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23  
year 1948 hour 8:10 minute P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis;  
Chronic interstitial nephritis.

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

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?

23. Signature: \_\_\_\_\_ (Specify type of place) (e) Means of injury 3  
Address: 1300 Clark Date signed 6-3-48

87619 700

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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..... No Embalm.....  
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.**