FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 14 1948
Registration District No. 577

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2002

State File No. 21602
Registrar's No. 1565

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6924 Roberts 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6924 Roberts Ave.
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

96
3
5
0

3. (a) PRINT FULL NAME Albert F. DeGuines

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Bertha T. DeGuines

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

7. Birth date of deceased April (Month) 24 (Day) 1874 (Year)

8. AGE: Years 74 | Months 1 | Days 26 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Retired

11. Industry or business Hotel Manager

FATHER
12. Name Unknown
13. Birthplace ____ (City, town, or county) France 5 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace ____ (City, town, or county) France 5 (State or foreign country)

16. (a) Informant Bertha T. DeGuines
(b) Address 6924 Roberts Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-48 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Mausoleum

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 6-23-48 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year 1948 hour 5:30 minute P M.

21. I hereby certify that I attended the deceased from Oct 1947 to June 20, 1948 that I last saw him alive on June 19, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Terminal Pneumonia	2 days
Due to Multiple Sclerosis	2 yrs
Due to 872	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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) no
(b) Date of occurrence none
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)
While at work? none (e) Means of injury none

23. Signature M E Stoehle 0 (M. D. or other) MD
Address 7124 Natural Bridge Date signed 6-22-48

(Licensed Embalmer's Statement on Reverse Side)

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 Gustav W Deutsch

Licensed Embalmer No. 4329

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.