

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9739**
Registrar's No. **2485**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 20 Yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION The St. Louis Altenheim		d. STREET ADDRESS (If rural, give location) 5408 So. Broadway			

3. NAME OF DECEASED (Type or Print) Lena Adolphi			4. DATE OF DEATH (Month) (Day) (Year) 3-16-49		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6-7-1860	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME UnKnown		13b. MOTHER'S MAIDEN NAME UnKnown		14. NAME OF HUSBAND OR WIFE Henry			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John W. Hoerr 5408 S Broadway			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 mo	
		ANTECEDENT CAUSES DUE TO (b) arterio sclerosis					
		DUE TO (c) Senility and Ch Impuritate				20 yrs.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. I had had 3 strokes since 1942					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis 8 Mo	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
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22. I hereby certify that I attended the deceased from **March 19 1949**, to **March 16 1949**, that I last saw the deceased alive on **March 16 1949**, and that death occurred at **8 14** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Miss Stauffer MD		23b. ADDRESS 512 Dorville		23c. DATE SIGNED 3/18/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Crementation		24b. DATE 3-19-1949		24c. NAME OF CEMETERY OR CREMATORY Mo. Crematory		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
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DATE REC'D BY LOCAL HEALTH DEPARTMENT MAR 19 1949		REGISTRAR'S SIGNATURE J. B. Zastner		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. P. Fendler Jr. 7128 Michigan			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2485

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Clarence Rochow

Signed.....

Student Embalmer

Licensed Embalmer No.

3093

P. O. Address.....

7128 Michigan

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.