

FILED NOV 25 1949

STANDARD CERTIFICATE OF DEATH

State File No. **38456**
Registrar's No. **9816**

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 OR TOWN ST. LOUIS		c. CITY OR TOWN ST LOUIS	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1605 UNION BLVD.	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL #1 B			

3. NAME OF DECEASED (Type or Print) a. (First) ALBERT b. (Middle) B. c. (Last) ALBRECHT			4. DATE OF DEATH (Month) (Day) (Year) NOV 14 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH July 4 1885		9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CROSSING WAKAMAN	
11. BIRTHPLACE (State or foreign country) St Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME BRUNO ALBRECHT	
13b. MOTHER'S MAIDEN NAME Selma U.K.		14. NAME OF HUSBAND OR WIFE DELTA		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lella Albrecht 1605 Union			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b)			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 MO	
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 HT 201	

22. I hereby certify that I attended the deceased from 1949, to 1949, that I last saw the deceased alive on 3 1/2 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph M. [Signature]		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 11/15/49	
24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		24b. DATE NOV 17 49		24c. NAME OF CEMETERY OR CREMATORY St. Peter's	
24d. LOCATION (City, town, or county) (State) Wentzton St. Louis Co. Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cellmer & Co. 4386 LINDELL BLVD			

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 15 1949 J. B. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cellmer & Co. 4386 LINDELL BLVD			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Student
Student Embalmer

Signed

James A. Lammers

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.