

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24224

6368

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2149			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				STREET ADDRESS (If rural, give location) 5881 Loran Ave. 8					
3. NAME OF DECEASED (Type or Print)		a. (First) Charles		b. (Middle) F.		c. (Last) Albrecht			
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1		8. DATE OF BIRTH Oct. 28, 1874			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years less birthday) 76		11. BIRTHPLACE (State or foreign country) 4 Germany			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Louisa					
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louisa Albrecht-5881 Loran-St. Louis					
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic endarteritis DUE TO (c) Diabetes II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 4/6/51	
19a. DATE OF OPERATION 6/19/51		19b. MAJOR FINDINGS OF OPERATION gangrene of left leg						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY/TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? Flex			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 4/6, 1951, to 7/16, 1951, that I last saw the deceased alive on 7/16, 1951, and that death occurred at 5:10 P. M., from the causes and on the date stated above.					
23a. SIGNATURE Jas. A. G. Jones M.D.		23b. ADDRESS 5521 S. Parkway		23c. DATE SIGNED 7/17/51					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0		24b. DATE 7/19/51		24c. NAME OF CEMETERY OR CREMATORY Lakewood Park		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.			
DATE RECD BY LOCAL REG. JUL 17 1951		REGISTRAR'S SIGNATURE J. B. Farster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hacker-Helders 3634 Gravois Ave.					

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Frank J. Hyland Jr.

Signed
Student Embalmer

Licensed Embalmer No. *2645*

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.