

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10852**

FILED MAR 22 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY St. Louis		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 Clayton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 6 hrs		6 2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital		d. STREET ADDRESS (If rural, give location) 1320-Laurel Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Louis	b. (Middle) _____	c. (Last) Alzheimer	(Month) Jan.	(Day) 17.	(Year) 1952

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 21, 1878	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor	10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME Soloman B. Alzheimer	13b. MOTHER'S MAIDEN NAME Miriam Simmons	14. NAME OF HUSBAND OR WIFE Florence I. Dod.
--	---	---

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. SS	17. INFORMANT'S SIGNATURE OR NAME Miriam Alzheimer	ADDRESS 1320-Laurel St. Louis, Mo.
--	-----------------------------------	---	---

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture with subdural and subarachnoid hemorrhage		
	ANTECEDENT CAUSES and subarachnoid hemorrhage Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) head laceration of brain 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 400+3	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------------	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. John's St. Louis Mo
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1/17/52 10:38 A.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Blunt impact
---	---	--

22. I hereby certify that I attended the deceased from 1-17, 1952 to 1-17, 1952, that I last saw the deceased alive on 1-17, 1952, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE Sahator N. Riggs MD (Degree or title)	23b. ADDRESS 601 S. Brentwood Clayton	23c. DATE SIGNED 1-18-52
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-19-1952	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. 1-18-52	REGISTRAR'S SIGNATURE Hershey R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE Blummann Bros. Inc.	ADDRESS 2501-Woodson Rd-Overland-14-Mo.
---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48
#111
0002

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 3454

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14

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.