

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26081
State File No.
6009
Registrar's No.

FILED JUL 31 1953

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY <u>City</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) (township) <u>71 yrs</u>	c. CITY OR TOWN <u>St. Louis</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res. 5409 Maple Ave.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <u>5409 Maple Ave.</u>		2059	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>M.</u> c. (Last) <u>Altman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 15, 1953</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 28, 1882</u>
9. AGE (In years last birthday) <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Leige, Belgium</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>August Bongartz</u>	13b. MOTHER'S MAIDEN NAME <u>Gertrude Osleander</u>	14. NAME OF HUSBAND OR WIFE <u>John Altman</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Miss Gertrude Pleuss</u>	ADDRESS <u>5409 Maple Ave.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive-Cardio-renal disease</u>		
	ANTECEDENT CAUSES <u>et renia</u> DUE TO (b) <u>Thrombus Left femoral artery</u> 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"/>
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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) _____
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? <u>442 X</u>

22. I hereby certify that I attended the deceased from 5/23, 1951, to 6/15, 1953, that I last saw the deceased alive on 6/15/53, and that death occurred at 11:45 AM., from the causes and on the date stated above.

23a. SIGNATURE <u>George Stecker M.D.</u>	(Degree or title) _____	23b. ADDRESS <u>634 N. Grand</u>	23c. DATE SIGNED <u>6/16/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>June 17, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla C rematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JUN 16 1953</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander & Sons, Inc.</u>	ADDRESS <u>6175 Delmar Bld</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. George Stecker
10:30 to 12 Daily
Mo. Theatre Bldg.
Je. 5354

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.....
Signature of Student Embalmer

Signed *jos. E. Mc Culloch*.....

Licensed Embalmer No. *246*

P. O. Address *6175 D*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.