

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24205

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5939

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) 30 yrs.
c. CITY OR TOWN St Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital
STREET ADDRESS (If rural, give location) 5400 Arsenal Street 2139

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) Altwater c. (Last) Altwater
4. DATE OF DEATH (Month) (Day) (Year) June 29, 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 8. DATE OF BIRTH Nov 21, 1896 9. AGE (In years last birthday) 57 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Illinois 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME William Smith 13b. MOTHER'S MAIDEN NAME Margaret Wolff 14. NAME OF HUSBAND OR WIFE Jake Altwater

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 Fred Schmid Shobonier Ill ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis 2 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic heart disease 2 yrs.
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 NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from 7-1, 1951, to 6-29, 1954, that I last saw the deceased alive on 6-29, 1954, and that death occurred at 7:35 Pm., from the causes and on the date stated above.

23a. SIGNATURE Cecelia Agnew MD (Degree or title) 23b. ADDRESS 5400 Arsenal Street 23c. DATE SIGNED 6-30-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 6-30-54 24c. NAME OF CEMETERY OR CREMATORY Shobonier Ill 24d. LOCATION (City, town, or county) (State) _____

DATE REC'D BY LOCAL REG JUL 1 1954 REGISTRAR'S SIGNATURE Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington

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.....
Signature of Student Embalmer

Signed..... *Paul A. Wechter*

Licensed Embalmer No. *4787*

P. O. Address *H. Davis*

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.