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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38505

State File No. ....

FILED NOV 22 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10370**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		f. STREET ADDRESS (If rural, give location) <b>5129 Wells Avenue., 20670</b>	

3. NAME OF DECEASED (Type or Print) <b>Hattie</b>	a. (First)	b. (Middle)	c. (Last) <b>Albrecht</b>	4. DATE OF DEATH <b>November 13, 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec 6, 1884</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Adam Trost</b>	13b. MOTHER'S MAIDEN NAME <b>Margarette Wittgreffe</b>	14. NAME OF HUSBAND OR WIFE <b>Bert Albrecht, dec'd</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>Nil</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charles Vierheller, 3121 Michigan</b>	ADDRESS
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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, 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) <b>Arterio Sclerotic Heart Disease</b>		<b>6 months</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b> DUE TO (c)		<b>2 years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes mellitus, cholecystitis</b>			<b>5 years 3 years</b>

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
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22. I hereby certify that I attended the deceased from **Sept 7<sup>th</sup>, 1944**, to **Nov 13<sup>th</sup>, 1954** that I last saw the deceased alive on **October 21, 1954**, and that death occurred at **3:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. H. McGehee M.D.</b>	23b. ADDRESS <b>3903 Olive</b>	23c. DATE SIGNED <b>11/15/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11-16-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bethany</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>NOV 15 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington Blvd</b>	ADDRESS
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(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 ....., Student Embalmer No..... working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed *John S. Henneke*.....  
Licensed Embalmer No. *419*.....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.