

FILED JAN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44299
2998
Registrar's No. 2998

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>Normandy</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>10 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>8107-St. Charles Road</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>8107-St. Charles Road</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Charles</u>	b. (Middle) <u>Andrew</u>	c. (Last) <u>Allmendinger</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 27, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 26, 1896</u>	9. AGE (In years last birthday) <u>58</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 10 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Cutter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dresses</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Andrew Allmendinger</u>	13b. MOTHER'S MAIDEN NAME <u>Pauline Schmidt</u>	14. NAME OF HUSBAND OR WIFE <u>Bertha Allmendinger</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.#1</u>	16. SOCIAL SECURITY NO. <u>4425</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bertha Allmendinger 8107-St. Charles</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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac insufficiency, Angina Pectoris</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> <u>7 years</u> DUE TO (c) <u>Arteriosclerosis Generalized</u> <u>7 years</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>4202</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Jan 1947 to Dec 27, 1954, that I last saw the deceased alive on Nov 27, 1954, and that death occurred at 7:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John W. Seddon M.D.</u>	23b. ADDRESS <u>4500 West Pine St. Louis Mo</u>	23c. DATE SIGNED <u>28 Dec 54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-30-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Normandy, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>12-28-54</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Seddon M.D.</u> ADDRESS <u>2504-Woodson Rd-Overland-14-Mo.</u>
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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 *Oscar F. Mueller*

Licensed Embalmer No. *303*

P. O. Address *Overland*

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.