

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18395

FILED MAY 24 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4309**

Health, Welfare, Public Service
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vector, coroner, etc. must use only standard nomenclature in Part 18. No symptoms written on natural causes. Coroner must be casually related. Coroner cannot certify to a death due to natural causes.
"USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE"

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <input checked="" type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Park Lane Hospital</u>		Length of stay in lb <u>6 days</u>	STREET ADDRESS <u>5822a Goener</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>C.</u> Last <u>Alt, Sr.</u>			4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1881</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Alt</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Morek</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-10-4129</u>	17. INFORMANT Address <u>Albert C. Alt, Jr., 5506 Heege Road</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Valvular Heart Disease - aortic insuff.</u> DUE TO (c) <u>Cardio Renal Vasculature Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>442x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u> <u>10 yrs</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month, Day, Year <u>p. m.</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>29 April</u> to <u>4 May</u> and last saw her alive on <u>4 May</u> Death occurred at <u>1:25 p m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <u>Rosemary R. Hoffman MD</u>			22b. ADDRESS <u>3284 Ivanhoe</u>		22c. DATE SIGNED <u>5-6-57</u>
23a. BURIAL, CREMATION, RENOVAL (Specify) <u>Cremation</u>	23b. DATE <u>May 7, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR'S ADDRESS <u>Hoffmeister Colonial Mortuary, 6464 Chippewa</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 6 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Rice C. Branson*

Licensed Embalmer No. *47*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.