FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

43023

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2886

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Ferndindand Tpw — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hallsferry Memorial — Length of stay in 1b Home 1 da 28

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 839 McLaran Ave — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last ALWES

4. DATE OF DEATH Month Day Year November 16th, 1957

5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH November 14th, 1874
9. AGE (In years last birthday) 83 — 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) Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY reitred
11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Henry Alwes
13b. MOTHER'S MAIDEN NAME Henrietta Spreck
14. NAME OF HUSBAND OR WIFE Agnes Alwes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ——
16. SOCIAL SECURITY NO. 489-01-3953
17. INFORMANT Address William H. Alwes, 4615 Steinlage

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 4 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteria - sclerosis — 10+ yrs
DUE TO (c) Senile degeneration
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11/1/57, to 11/16/57 and last saw her/him alive on 11/16/57
Death occurred at 6:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS 8321 N. B'dway
22c. DATE SIGNED 11/17/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 1/20/57
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS DIEDRICH FUNERAL HOME, 8319 Hallsferry
25. DATE RECD. BY LOCAL REG. 11-18-57
26. REGISTRAR'S SIGNATURE Herbert B. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Stanley H. Gibson

Licensed Embalmer No. 4193

P. O. Address St. L.

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.