

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019925  
STATE FILE NUMBER

HEU JUN 9 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1518

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Groves</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>151 Gray Ave.</b>		Length of stay in lb Years	d. STREET ADDRESS (If outside, give location) <b>151 Gray Ave.</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LYDIA PAULY ALT</b>			4. DATE OF DEATH Month Day Year <b>6-2-1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1878</b>
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 country) <b>St. Louis Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>G.A. Pauly</b>	
13b. MOTHER'S MAIDEN NAME <b>Lena Heckmann</b>		14. NAME OF HUSBAND OR WIFE <b>Edward Alt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>G.P. Alt</b> Address <b>304 S. Elm Ave. Web. Groves</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			<b>Year</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>			<b>Year</b>
DUE TO (c) <b>Terminal Bronchio-pneumonia</b>			<b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>4200</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20h. CITY, TOWN, OR LOCATION	
21. I attended the deceased from <b>2-1-41</b> to <b>6-2-59</b> and last saw her alive on <b>5-31-59</b>		22. ADDRESS <b>204 E. Big Bend</b>	
Death occurred at <b>12:45 AM</b> on the date, stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <b>6-2-59</b>	
22a. SIGNATURE (Degree or title) <i>Edward Alt</i>		22b. ADDRESS <b>204 E. Big Bend</b>	
23a. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23b. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
24. FUNERAL DIRECTOR <b>Parker-Aldrich Webster Groves Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-3-59</b>	
26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>		27. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... *Leslie Welch* .....

Licensed Embalmer No. *4395* .....

P. O. Address *White Grove* .....

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.