

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026354

FILED VS JUL 24 1959

STATE FILE NUMBER
2 6265

Registration District No. Primary Registration District No. Registrar No.

300
-57

94
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hosp.		d. STREET ADDRESS 3666 Cleveland	

3. NAME OF DECEASED (Type or print) First Middle Last Nellie L Allmeroth			4. DATE OF DEATH Month Day Year June 30 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23 1885	9. AGE (In years last birthday) 73	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jules Jeep	13b. MOTHER'S MAIDEN NAME Minerva	14. NAME OF HUSBAND OR WIFE William L ALLMEROOTH
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, NO (unknown)) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Bernice Schmidt 16 Ramsey La Ballwin
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Left Ankle</i> <i>Cardiac Hypertrophy</i> <i>Cerebral Apoplexy</i>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>E904.0</i>		

20a. ACCIDENT <input checked="" 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.) <i>Suffered in fall June 13th 1959.</i>
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20c. TIME OF INJURY Hour a.m. p.m. <i>6 13 59</i>	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.) <i>174 House</i>	20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>
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21. I attended the deceased from Death occurred at <i>205 A</i> to <i>205 A</i> and last saw her alive on <i>7/2/59</i>	22a. SIGNATURE <i>E. J. Schnur</i>	22b. ADDRESS <i>1300 Chest</i>	22c. DATE SIGNED <i>7/2/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <i>7/2/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New St. Marcus</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Cty Mo.</i>
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24. FUNERAL DIRECTOR E. J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. JUL 2 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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 *Thomas R. Jenwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.