MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25074

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St Louis (No. 3125 MORGANFORD St. ..... Ward)

File No. ..... Registered No. 7270.

2. FULL NAME ALICE ALBRECHT

(a) Residence. No. 3125 Morganford St., 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
FEMALE	WHITE	MARRIED

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WM. M. ALBRECHT

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JAN-13-1899

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work SUPERVISOR
(b) General nature of industry, business, or establishment in which employed (or employer) DINING ROOM
(c) Name of employer CITY HOSPITAL

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) NEBRASKA

PARENTS

10. NAME OF FATHER GEO. DONALDSON

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) NEBRASKA

12. MAIDEN NAME OF MOTHER DONT KNOW

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) DONT KNOW

14. INFORMANT Wm M Albrecht
(Address) 3125 Morganford Rd.

15. FILED JUL 21 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JULY 19 1930

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 19, 1930, that I last saw her alive on July 19, 1930, and that death occurred, on the date stated above at 12 33 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93A
95B Typhoid Fever (duration) ..... yrs. ..... mos. 28 ds.
Acute
CONTRIBUTORY (SECONDARY) Myocarditis +
Acute Dilatation Heart (duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED Dont know
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical + Bacteriological
(Signed) [signature] M. D.
July 20, 1930 (Address) 3146 Morganford

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL NEW ST. MATTHEWS — DATE OF BURIAL JUL 22 1930

20. UNDERTAKER CENTRAL — ADDRESS 6401 So. 9th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD