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

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.

1 X12004

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

OCT 14 1937

32484
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 8538
(c) City St. Louis (d) Street No. 6037 Carlsbad Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Alt
(a) Residence, No. 6037 Carlsbad Ave. St. 2
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Alt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April, 1st. 1870.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
67	5	8	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired (3yrs)
9. Industry or business in which work was done, as saw mill, bank, etc. Beer Bottler
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La Salle Illinois

FATHER
13. NAME William Alt
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alsac Loraine France

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Kate Alt 6037 Carlsbad Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE New St. Marcus DATE Sept. 13- 1937

19. FUNERAL DIRECTOR (ADDRESS) Wacker-Helderle 2331 S. Broadway

20. FILED SEP 11 1937 J F Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 9th. 1937

22. I HEREBY CERTIFY, That I attended deceased from July 5, 1937, to Sept 9, 1937
I last saw him alive on 9/9/37, 19.... Death is said to have occurred on the date stated above, at 3.35 P.M.
The principal cause of death and related causes of importance were as follows:

Chronic - Myocardial — Date of onset ??

Other contributory causes of importance: None

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) William Dynko, M. D.
(Address) 3193 Broadway

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Frank J. Ohyland, Licensed Embalmer No. 2645

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. 2645 or by, Registered Apprentice No.

working under my personal supervision.

Signed Frank J. Ohyland

Licensed Embalmer No. 2645

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.)