

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19501
Registrar's No. 1021

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jennings
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8723 Clifton Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Jennings
(If outside city or town limits, write "RURAL")
(d) Street No. 8723 Clifton Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Albertena Edelmann
8. (b) If veteran, name war _____ 8. (c) Social Security No. None
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 19 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 26
year 1940 hour 4:30 minute P M.
21. I hereby certify that I attended the deceased from April 6 1940 to May 26 1940
that I last saw her alive on May 28 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 11 Days 7 If less than one day _____ hr. _____ min.
9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Nurse
11. Industry or business _____
12. Name Frank Edelmann
13. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name Anna Schaefer
15. Birthplace Belleville Ill
(City, town, or county) (State or foreign country)

Immediate cause of death Chronic Corne Distention Duration 1 day
Due to Chronic myo carditis Atherosclerosis Diabetes Chronic Interstitial Nephritis 59
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant's own signature John Edelmann
(b) Address 8723 Clifton Ave
17. (a) Burial (b) Date thereof May 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Bethlehem Cem
18. (a) Signature of funeral director Beiderwieden Funl Home
(b) Address 1936 St Louis Ave
19. (a) MAY 28 1940 (b) R. M. ...
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature H. G. ... (M. D. or other) 5/28/40
Address 5428 Harris av. Date signed 5/28/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

U. S. G. P. 2.
DOM-5-17-39
Rev. 5-17-39
1 X1811

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Felix J. Krupin*

Licensed Embalmer No. 3497

P. O. Address 1936 St. Louis Ave

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 this body is not embalmed, above space should be left blank.