

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 33825
Registrar's No. 8522

Registration District No. 791 Primary Registration District No.

PLACE OF DEATH:

County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5139 Wabada
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME George F. Altemeyer

3. (b) If veteran, name war None 3. (c) Social Security No. 491-16-6780

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lizzie Altemeyer 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 8 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 5 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Freight Handler

11. Industry or business Associated Grocers Inc.

12. Name Herman Altemeyer

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lizzie Altemeyer

(b) Address 5139 Wabada

17. (a) Burial (b) Date thereof Oct 16 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Lebanon

18. (a) Signature of funeral director A. K. ...

(b) Address 2707 N Grand Blvd

19. (a) OCT 15 1940 (b) J. B. ...
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5139 Wabada
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1940 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from Dec 2 and
1938 to Oct. 13 - 19 40
that I last saw him alive on Oct 11 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration for years

Due to _____
Due to _____

Other conditions Chronic Interstitial Nephritis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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 Peter A. Eck (M.D. or other) _____
Address 4701 St Louis Ave Date signed 10/14/40

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.....

Paul F. Krollenberg

Licensed Embalmer No. *2631*

P. O. Address *2707 N. 1st St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.