

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County **St Louis Mo**
(b) City or town **St Louis Mo**
(c) Name of hospital or institution: **The St Louis Altzheimer (C)**
(d) Length of stay: In hospital or institution **11 yrs - 28 days**
In this community **11 yrs - 28 days**

3. (a) PRINT FULL NAME **Bertha Attmann**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive **28** years

7. Birth date of deceased **Aug 28 1852**
(Month) (Day) (Year)

8. AGE: Years **89** Months **2** Days
If less than one day hr. _____ min.

9. Birthplace **Germany** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**
11. Industry or business _____

MOTHER FATHER
12. Name
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace **GERMANY** (City, town, or county) (State or foreign country)
16. (a) Informant's own signature **[Signature]**
(b) Address **5408 S Broadway**
17. (a) New St Marcar (b) Date thereof **10. 25 41**
(c) Place: burial or cremation **New St Marcar**
18. (a) Signature of funeral director **[Signature]**
(b) Address **504 Delaware**
19. **OCT 28 1941** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **0000**
(c) City or town **St Louis**
(d) Street No. **5408 S Broadway**
(e) If foreign born, how long in U. S. A. **Since 1880** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **28** year **1941** hour **4 AM** minute _____ M.
21. I hereby certify that I attended the deceased from **Jan - 39** to **Oct 27/41** that I last saw her alive on **Oct 27/41** and that death occurred on the date and hour stated above.

Immediate cause of death **Ch. Myocarditis** Duration **5 yrs**
Due to **arteriosclerosis**
Due to _____
Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **None**
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) **None**
(b) Date of occurrence **None**
(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 **Max Stubbhoff** (M. D. or other) **[Signature]**
Address **512 Dan Place** Date signed _____

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Howard T. Rowland

Licensed Embalmer No.

3114

P. O. Address.....

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.