

FILED APR 8 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8210  
State File No. \_\_\_\_\_  
2304  
Registrar's No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Depaul Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Infant Allhoff

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 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 March 9, 1942  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Nil.

11. Industry or business \_\_\_\_\_

12. Name Joseph Allhoff

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

14. Maiden name Marie Winterglien

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

16. (a) Informant Joseph Allhoff

(b) Address 1447A Hamilton Ave.,

17. (a) Burial (b) Date thereof Mar. 14/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.,

19. (a) MAD 12 1942 (b) J. F. Medek  
(Date received local registrar's certificate) (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. 1447A Hamilton Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12  
year 1942 hour 6:00 minute \_\_\_\_\_ P.M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from: 3/9, 1942 to 3/12, 1942  
that I last saw him im alive on 3/12, 1942  
and that death occurred on the date and hour stated above.

Impedate cause of death Cerebral Hemorrhage Duration 3 da.

Due to Birth Injury

Due to Head  
Other conditions Cerebral Hemorrhage  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 10/11  
Of autopsy Cerebral Hemorrhage

PHYSICIAN

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 Charles H. ... M. D. or other \_\_\_\_\_  
Address 3711 Lee Ave. Date signed 3/13/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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17  
9

Dr. C.E. Martin  
3911 Lee Ave.,  
Ce. 2313.  
1-3 P.M.

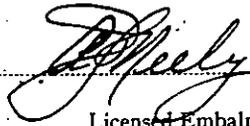
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**STATEMENT BY LICENSED EMBALMER**

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.....



Licensed Embalmer No. 3225

P. O. Address. 1125 Hodiament 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, fact should be so stated above.**