

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35636

State File No. _____

NOV 13 1943

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2490

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6407 Wells Ave.,
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Joseph Alte Sr.

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, widowed

6. (b) Name of husband or wife Alice Alte 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 23, 1854.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 5 15 hr. min.

9. Birthplace Sparta, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Major Alte

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

14. Maiden name Lucendia Mason

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

16. (a) Informant Joseph H. Alte Jr.,

(b) Address 6407 Wells Ave.,

17. (a) Burial (b) Date thereof Nov. 9/43.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.,

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

(b) Address 1125 Hodiamont Ave.,
19. (a) NOV 9- 1943 (b) E. G. Mc Garrison, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 6407 Wells Ave.,
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 7
year 1943 hour 12.15 minute A.M.

21. I hereby certify that I attended the deceased from about
June 1944 to Oct 1943
that I last saw him alive on Oct. 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
General Arterio-sclerosis

Due to Similarity

Due to _____
Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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)
(a) Means of injury _____
23. Signature Doyle A. King (M. D. or other) MD
Address 7166 Manchester Date signed 11/9/43

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

Dr. Douglas Ries,
1222 Highland
St. 1054.
Leit. at St. John Hospital.

DEC 7 1948

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: *J. W. Wilkin*
Licensed Embalmer No. 3575
P. O. Address St. Louis, Mo.

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.