V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 14549

Registrar's No. 275

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town RIVERVIEW GARDENS (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOME 9949 LICLAC DR. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE (Specify whether

In this community 20 YR. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town RIVERVIEW GARDENS (If outside city or town limits, write "RURAL")

(d) Street No. 9949 LICLAC DR (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ADELINE HALTEMAN

3. (b) If veteran, name war NONE

3. (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 NOV. (Month) 14. (Day) 1874 (Year)

8. AGE: Years 70 Months 4 Days 12 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business

FATHER
12. Name ABERHAM HALTEMAN
13. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)

MOTHER
14. Maiden name CECELIA BROOKS
15. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)

16. (a) Informant Albert Halteman

(b) Address 9949 Laclac Dr

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof MARCH 28/1945 (Month) (Day) (Year)

(c) Place: burial or cremation ST. PETERS N. Bridge

18. (a) Signature of funeral director Diedrich F. Home

(b) Address 8319 Halls Ferry Rd

19. (a) MAR 27 1945 (Date received local registrar) (b) V.V.E. G. McGovern (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 26 year 1945 hour 1 40 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, to March 26, 1945 that I last saw her alive on March 25, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Mitral regurgitation	5 yr
Due to not known	
Due to	
Other conditions chronic myocarditis (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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) none

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. F. Miller (M. D. [redacted])

Address 8410 N. Broadway St Louis MO Date signed 3/27/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

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, fact should be so stated above.