

S. No. 2  
M-2-43  
7-5-17-39  
V-1 X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35000

FILED NOV 19 1945

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9750

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

1. PLACE OF DEATH:

(a) 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:  
3139 PARK AV. 1  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000  
17

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL") 18

(d) Street No. 3139 PARK AV.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME THEODORE ALBRECHT

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9  
year 1945 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 18 1945 to Nov 9 1945  
that I last saw him alive on Nov 8 1945  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife ROSE MARIE ALBRECHT 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: SEPT 21 1866  
(Month) (Day) (Year)

Immediate cause of death: Chronic myocarditis  
Atherosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: Chronic Hypertension  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

79 1 19 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: GERMANY  
(City, town, or county) (State or foreign country)

10. Usual occupation: nil

Major findings: Of operations \_\_\_\_\_

Of autopsy: 121

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name: UNK. Albrecht

13. Birthplace: GERMANY 4  
(City, town, or county) (State or foreign country)

14. Maiden name: MARIE UNKNOWN

15. Birthplace: GERMANY 4  
(City, town, or county) (State or foreign country)

16. (a) Informant: Bernice Albrecht  
(b) Address: 3139 PARK AV

17. (a) BURIAL (b) Date thereof: Nov 12 - 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Concordia Cemetery

18. (a) Signature of funeral director: E. J. Schur  
(b) Address: 3125 Lafayette Av.

19. (a) NOV 10 1945 (b) J. F. Bradeck  
(Date received by Registrar) (Registrar's signature)

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) Means of injury: 0

23. Signature: Otto C. Hausner (M. D. or other) MD  
Address: 3157 1/2 Park Av Date signed: 11/9/45

444 (Licensed Embalmer's Statement on Reverse Side)

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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 *Joe B. Vollmer*.....

Licensed Embalmer No. *41014*.....

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.**