V. S. No. 2
100M—5-43
Rev. 5-17-39
No. 1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35730

FILED DEC 7 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10196

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 50
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. House Springs Missouri. NR
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alice Pfeiffer

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 Married

6. (b) Name of husband or wife Antone

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased September 17th, 1907 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
38	2	6	hr. min.

9. Birthplace Murphy (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation At home.

11. Industry or business

FATHER
12. Name John A Chott
13. Birthplace Rock Creek (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Theresa Weber
15. Birthplace Jefferson County (City, town, or county) 0 (State or foreign country)

16. (a) Informant Antone Pfeiffer
(b) Address House Springs R. R. 1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation N. SS. Peter & Paul

18. (a) Signature of funeral director J. J. Bugenhagen
(b) Address 7027 Gravois Ave.

19. (a) NOV 26 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nove. day 23rd, year 1945. hour 4 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 22, 1945, to Nov. 23, 1945; that I last saw her alive on Nov. 22, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Shock due to Hemorrhage	8 hrs.
Due to: Ectopic gestation, ruptured	6-8 wks.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations ruptured bleeding pregnancy
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. Lewis Hutter (M. D. or other) M. D.
Address 3606 Gravois Date signed 11/24/45

(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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 7027 Gravois

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.