

FILED JUL 30 1946

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Mary's Hospital  
(If not in hospital or institution, give street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 days (Specify whether years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Randolph  
(c) City or town Prairie du Rocher  
(If outside city or town limits, write "RURAL")  
(d) Street No. ST. MARY'S HOSPITAL  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Pamlet Albert

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 5

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

7. Birth date of deceased 7 17 1946  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 1/2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Richmond Heights, St. L. County, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Orville Albert  
13. Birthplace Prairie du Rocher, Ill.  
(City, town, or county) (State or foreign country)  
14. Maiden name Jane Hyatt  
15. Birthplace Prairie du Rocher, Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Orville Albert

(b) Address Prairie du Rocher, Ill.

17. (a) Removal (b) Date thereof 7-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prairie du Rocher, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 7-22-46 (b) Ed. J. Garant  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 1946  
year 7 hour 55 minute P.M.

21. I hereby certify that I attended the deceased from July 17, 1946 to July 19, 1946  
that I last saw her alive on July 19, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (34 wk)

Due to Eclampsia of mother

Due to 159

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

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 Bernard W. Gerwitz (M. D.)  
Address 506 N. Grand Date signed 7/19/46

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

76  
208

COPIES

**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 Henry M. Brammer

Licensed Embalmer No. 4200

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.**