

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43066**
Registrar's No. **10388**

FILED DEC 17 1946
318

Registration District No. _____ Primary Registration District No. _____

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: **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **15 yrs 9 mos 12 ds**
49 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ALDINA VOLLE**

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 **single**

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

7. Birth date of deceased: **Nov 15 1886**
(Month) (Day) (Year)

8. AGE: Years **62** Months **9** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **New Minden Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Seamstress**

11. Industry or business _____

12. Name **Charles Valle**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **not known Louise Matt Meyer**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Thelma Augler**

(b) Address **5400 Arsenal St**

17. (a) **Burial** (b) Date thereof **12-5-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Margus Cem**

18. (a) Signature of funeral director **W. B. R. & G.**

(b) Address **2924 S. Jefferson Av**

19. (a) **DEC 5 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street **7509 S. Grand**
City Sanitarium (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** Day **3rd**
Year **1946** hour **1:25** minute **A.** M.

21. I hereby certify that I attended the deceased from **Febr., 15 46** to **Dec 3, 1946**
that I last saw her alive on **Dec 3, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death
Schizophrenia 1946x
Arteriosclerosis 1946x.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **97**

Major findings: Of operations _____

Of autopsy **No**

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) (c) Means of injury _____

23. Signature **Jack ...** (M. D. or other) _____

Address **5400 Arsenal St** Date signed _____

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

MOTHER FATHER

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 *A. M. Davis*
Licensed Embalmer No. 3741
P. O. Address 2929 Jefferson

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.