

No. 2  
2-45  
17-39  
X47070

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 13 1948  
318  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27920  
7620  
State File No.  
Registrar's No.

Registration District No. Primary Registration District No. 100

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME KONSTANZER, ALBERT H. B.

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 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 October 15 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 10 13 hr. min.

9. Birthplace Looking Glass Prairie, Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Albert Konstanzer

13. Birthplace Mascoutah Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Fredericka Borgmann

15. Birthplace New Memphis Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant E. H. Sager

(b) Address Kirkwood, Missouri

17. (a) Removal (b) Date thereof 8-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mascoutah, Ill.

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

(b) Address 4700 Washington Blvd.

19. (a) AUG 30 1948 (b) AUG 30 1948  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Clinton 999  
(c) City or town New Memphis 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. NR 6  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 2  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 28TH  
year 1948 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from August 23, 1948, to Aug. 28, 1948  
that I last saw him alive on Aug. 28, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death MALNUTRITION Duration 2 MO

Due to CARCINOMATOSIS ?

EPIDERMAL  
Due to A CARCINOMA OF LARYNX 1 YR

Other conditions  
(Include pregnancy within 3 months of death)

Major findings: Of operations CARCINOMA OF LARYNX PHYSICIAN

Of autopsy CARCINOMA OF LARYNX  
ASPIRATION PNEUMONIA  
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? (c) Means of injury.

23. Signature C. O. Vermillion (M-D)  
Address Barnes Hospital Date signed 8-28-48

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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 Elmer R. Cadwell

Licensed Embalmer No. 4077

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.**