

10-47
-17-39
I 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34563
Registrar's No. 9607

FILED NOV 12 1948
Registration District No. 1003
Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Missouri.
(b) City or town St. Louis, Missouri.
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(d) Length of stay: In hospital or institution 11 (Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME ALVIN PFLUGBEIL
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ANNA PFLUGBEIL
6. (c) Age of husband or wife if alive 28-1872
7. Birth date of deceased DECEMBER 28-1872

8. AGE: 75 Years 10 Months 0 Days If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER {
12. Name AUGUST PFLUGBEIL
13. Birthplace GERMANY
14. Maiden name UNKNOWN
15. Birthplace GERMANY

16. (a) Informant _____
(b) Address 3219 A. EADS AV.

17. (a) BURIAL (b) Date thereof NOV. 4-48
(c) Place: burial or cremation ST. JACOBS CH.

18. (a) Signature of funeral director E. J. Schnerl
(b) Address 3125 LAFAYETTE AV.

19. (a) NOV 4 1948 (b) J. B. Sarator (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town ST. LOUIS
(d) Memorial No. 3219 A EADS AV.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 3rd year 1948 hour 11 minute 15 A M.
21. I hereby certify that I attended the deceased from Nov. 3rd 1948 to Nov. 3rd 1948
that I last saw him alive on Nov. 3rd 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Azoemia
Due to: Arteriosclerotic heart disease
Due to: Renal azoemia
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Not permitted
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? _____

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

23. Signature E. J. Schnerl (M. D. or other)
Address 1515 Lafayette 11/3/48 (Date signed)

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

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.....

John Ballma

Licensed Embalmer No.....

41014

P. O. Address.....

3125 Sepyettan Y

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.