No. 300
10.48

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18037

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1161

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chesterfield 3
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ascension Church

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO.
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chesterfield
d. STREET ADDRESS (If rural, give location) Route 1,

3. NAME OF DECEASED (Type or Print)
a. (First) Catherine
b. (Middle)
c. (Last) Albrecht

4. DATE OF DEATH (Month) 5- (Day) 8- (Year) 49

5. SEX Fe.
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 1, 1893
9. AGE (In years last birthday) 55 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) St. Louis Co.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Wm. Essen
13b. MOTHER'S MAIDEN NAME Adelia Jones
14. NAME OF HUSBAND OR WIFE Charles F. Albrecht

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Charles F. Albrecht — **ADDRESS** Route 1, Chesterfield

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myocarditis. — 1 year.
DUE TO (c) 4201

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none — 93d

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none.
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 23, 1944, *to* May 8, 1949, *that I last saw the deceased alive on* May 3, 1949, *and that death occurred at* 7:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] **(Degree or title)** D **23b. ADDRESS** Eureka, Mo. **23c. DATE SIGNED** 5-9-49.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 5-11-49
24c. NAME OF CEMETERY OR CREMATORY Gumbo Cem.
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 5-11-49
REGISTRAR'S SIGNATURE [signature] MD
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** Ortmann F. Home 9222 Lackland

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Al C. Ortmann

Licensed Embalmer No. 3478

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.