

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2250

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 3	
1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. CHARLES RURAL</b>		c. LENGTH OF STAY (in this place) <b>28 YEARS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>UNKNOWN</b>		d. STREET ADDRESS (If rural, give location) <b>UNKNOWN</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>EVANGELICAL ENHAUS HOME</b>				d. STREET ADDRESS (If rural, give location) <b>UNKNOWN</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>EDITH</b>		b. (Middle) <b>GERTRUDE</b>		c. (Last) <b>ALEXANDER</b>	
4. DATE OF DEATH		(Month) <b>JANUARY</b>		(Day) <b>2</b>		(Year) <b>1951</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>SEPT. 1, 1908</b>	
9. AGE (In years last birthday) <b>42</b>		If UNDER 1 YEAR Months _____ Days _____		If UNDER 2 WKS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Joseph Storker</b> ADDRESS <b>ST. CHARLES, MO.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Tuberc. Pneumonia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Manic Depressive</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>490X</b>  <b>25 yrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>Jan 1, 1951</b> , to <b>Jan 2nd, 1951</b> , that I last saw the deceased alive on <b>Jan 1st, 1951</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>D. P. Enrich, Schickel, Ord.</b>		23b. ADDRESS <b>St. Charles, Mo.</b>		23c. DATE SIGNED <b>1/3/51</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24b. DATE <b>Jan 4 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Euclid Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Charles, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>Jan 11 1950</b>		REGISTRAR'S SIGNATURE <b>Marine Hamilton</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. K. Krumm</b>		ADDRESS <b>Base St. Charles</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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than

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

JAN 15 1951

RECEIVED

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_ *Frederic W. Bane*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4607

P. O. Address St. Charles, Mo.

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.