

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18939

State File No. ....

BIRTH NO. ... REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2092

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Florissant</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Florissant</u>	
c. LENGTH OF STAY (In this place) <u>years</u>		d. STREET ADDRESS (If rural, give location) <u>1070 Castello St.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: <u>1070 Castello St.</u>			

3. NAME OF DECEASED a. (First) <u>Elizabeth</u> b. (Middle) <u>Albers</u> c. (Last) <u>Albers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 6, 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 10, 1864</u>	9. AGE (In years last birthday) <u>86</u> IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Florissant, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>John Stroer</u>		13b. MOTHER'S MAIDEN NAME <u>Angela Behlmann</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Albers (Dec'd)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Angela Albers, Florissant, Mo.</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Regenerative cardio-vascular disease</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS <u>Auricular fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  <u>Yrs.</u>  <u>days</u>
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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 2 May, 1951, to 6 May, 1951, that I last saw the deceased alive on 6 May, 1951, and that death occurred at 5 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. Ferguson</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>225. Florissant</u>		23c. DATE SIGNED <u>5/7/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/9/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Florissant, Mo.</u>		DATE REC'D BY LOCAL REG. <u>5/7/51</u> REGISTRAR'S SIGNATURE <u>Herbert P. Lomke M.D.</u> FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>White Chapel Ferguson, Mo.</u>			

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

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Wm. Ferguson

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 \_\_\_\_\_

*L. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Perquimans, Va.*

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.