

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40073

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3066 Registrar's No. 3927

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

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 _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirkwood</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>18</u>		d. STREET ADDRESS (If rural, give location) <u>4368 W. Bell</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Public Health Service Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gustave (Sr.)</u> b. (Middle) _____ c. (Last) <u>ALEXANDER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>December 6, 1951</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Mar. 12, 1895</u>		9. AGE (In years last birthday) <u>56</u>		10. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR.: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Little Rock, Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY? _____					

13a. FATHER'S NAME <u>John Alexander</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Warren</u>		14. NAME OF HUSBAND OR WIFE <u>Felicia Alexander</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>U.S. Public Health Service</u>	
				ADDRESS <u>525 Couch Ave. Kirkwood, Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) <u>Arteriosclerosis of coronary arteries</u>		unknown	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		unknown	
		<u>Gastric ulcer with hemorrhage</u>			

19a. DATE OF OPERATION <u>11-20-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Partial gastrectomy</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4206</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Nov. 18th, 1951, to Dec. 6th, 1951, that I last saw the deceased alive on Dec. 6th, 1951, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Lloyd S. Rolufs, Sr. Surg.</u> (Degree or title)		23b. ADDRESS <u>U.S. Public Health Service Hospital, Kirkwood, Mo.</u>		23c. DATE SIGNED <u>Dec. 7, 1951</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-10-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo</u>	
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DATE REC'D BY LOCAL REG. <u>12-8-51</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dornik M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Gates, 4107 Finney Ave.</u>		ADDRESS	
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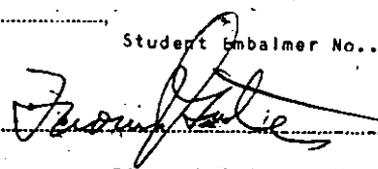
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_



Signed .....  
Student Embalmer

Licensed Embalmer No. 4259

P. O. Address 4107 7<sup>th</sup>

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.