

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

43251

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11308**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo. 2249			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2820 So. 9th st.		d. STREET ADDRESS 2820 So 9th st		24			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Lou		c. (Last) Alterhaus			
4. DATE OF DEATH (Month) (Day) (Year) 12 6 1952		5. SEX Female		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Jan 11 1948		9. AGE (In years last birthday) 4 IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) St. Louis Mo.			
12. CITIZEN OF WHAT COUNTRY? C		13a. FATHER'S NAME Clarence Alterhaus		13b. MOTHER'S MAIDEN NAME Louise Sullivan			
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No			
17. INFORMANT'S SIGNATURE OR NAME Clarence Alterhaus		ADDRESS 2820 S. 9th St					
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) Malnutrition ANTECEDENT CAUSES DUE TO (b) Anemia DUE TO (c) Severe birth to head injury II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 293X			
22. I hereby certify that I attended the deceased from Jan 10, 1949, to Dec 5, 1952 , that I last saw the deceased alive on 7/2/5 , 1952, and that death occurred at 7 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Clarence P. Scott M.D.		23b. ADDRESS 3258 Lafayette Ave		23c. DATE SIGNED 12-8-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/9/52		24c. NAME OF CEMETERY OR CREMATORY Memorial Park			
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan		ADDRESS 2849 N. Euclid ave			
DATE REC'D BY LOCAL REG. DEC 8 1952		REGISTRAR'S SIGNATURE Carl Smith M.D.					

(Licensed Embalmer's Statement on Reverse Side)

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

Prescribed name of death

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 *Robert L. Bunkema* _____

Licensed Embalmer No. *3553* _____

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 licenss.)

If this body is not embalmed, fact should be so stated above.