

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26971**  
**6209**

FILED JUL 31 1953  
BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |  | c. CITY OR TOWN <b>St. Louis</b>  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>9 yrs.</b>   |  | e. STREET ADDRESS (If rural, give location) <b>15 5400 So. Broadway 2159</b>  |   |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis Altenheim</b> |  |   |   |

|                                     |                          |                       |                         |   |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Sophia</b> | b. (Middle) <b>--</b> | c. (Last) <b>Ulrich</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 20, 1953.</b> |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|

|                      |                               |  |                                      |   |                         |                       |   |
|----------------------|-------------------------------|--|--------------------------------------|---|-------------------------|-----------------------|---|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b> | 8. DATE OF BIRTH <b>Jan. 1, 1863</b> | 9. AGE (In years last birthday) <b>90</b> | 10. UNDER 1 YEAR Months | 11. UNDER 1 HR. Hours | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b> |
|----------------------|-------------------------------|--|--------------------------------------|---|-------------------------|-----------------------|---|

|  |  |  |   |
|--|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods Store</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis County, Mo</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b> |
|--|--|--|---|

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|--|---|---|
| 13a. FATHER'S NAME <b>Christian Ulrich</b> | 13b. MOTHER'S MAIDEN NAME <b>Catherine Gruber</b> | 14. NAME OF HUSBAND OR WIFE <b>Single</b> |
|--|---|---|

|   |                                     |   |         |
|---|-------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Mo</b> | 16. SOCIAL SECURITY NO. <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Sophia Ulrich, Ferguson, Mo.</b> | ADDRESS |
|---|-------------------------------------|---|---------|

|   |   |          |  |
|---|---|----------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |          | INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>   |          | <b>?</b>   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Arterio Sclerosis</b><br>DUE TO (c) <b>Ch. Myocarditis</b> |          | <b>?</b>   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Senility</b>   |   | <b>?</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) <b>St. Louis Mo Mo</b> |
|--|--|--|

|  |  |   |
|--|--|---|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>420 ft.</b> |
|--|--|---|

22. I hereby certify that I attended the deceased from **Jan 11, 1949** to **June 20, 1953**, that I last saw the deceased alive on **June 20, 1953**, and that death occurred at **7:00 P.M.**, from the causes and on the date stated above.

|   |                                     |                                 |
|---|-------------------------------------|---------------------------------|
| 23a. SIGNATURE <b>Max Stordoff M.D.</b> (Degree or title) | 23b. ADDRESS <b>512 Doran Place</b> | 23c. DATE SIGNED <b>6/21/53</b> |
|---|-------------------------------------|---------------------------------|

|  |                           |   |  |
|--|---------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>6/23/53.</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b> |
|--|---------------------------|---|--|

|  |   |   |         |
|--|---|---|---------|
| DATE REC'D BY LOCAL <b>JUN 22 1953</b> | REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>White Chapel, Ferguson, Mo.</b> | ADDRESS |
|--|---|---|---------|

**E.P.** (Licensed Embalmer's Statement on Reverse Side)

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

4

80.1306

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.....  
Signature of Student Embalmer

Signed *L. M. White*.....

Licensed Embalmer No. *397*

P. O. Address *Perquimans*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.