FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32814

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8256

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOHN'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS, 2109
d. STREET ADDRESS (If rural, give location) 4222 west SACRAMENTO AVE

3. NAME OF DECEASED (Type or Print)
a. (First) MILLIE
b. (Middle) L.
c. (Last) ALFERMAN

4. DATE OF DEATH (Month) (Day) (Year) AUG, 25, 1953

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH 9/17/1887
9. AGE (In years last birthday) 65 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) ST. CHARLES MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME HENRY ALFERMAN
13b. MOTHER'S MAIDEN NAME MARY SCHAEFFER
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME TERESA ALFERMAN **ADDRESS** 4222 W. SACRAMENTO AVE

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2

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. Bronchi. Pneumonia — 3 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 443.X

22. *I hereby certify that I attended the deceased from* August 1, 1953, *to* Aug 25, 1953, *that I last saw the deceased alive on* Aug 25, 1953, *and that death occurred at* 4:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE A. P. Munsch (Degree or title) M.D.
23b. ADDRESS 306 Humboldt Bldg
23c. DATE SIGNED Aug 26/53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 8/28/53
24c. NAME OF CEMETERY OR CREMATORY ST CHARLES BARROMEO
24d. LOCATION (City, town, or county) (State) ST. CHARLES MISSOURI

DATE REC'D BY LOCAL REG. AUG 26 1953
REGISTRAR'S SIGNATURE J. Earl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE

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

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

Dr A P Munsch
St Johns Hosp
10 am

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 M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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