

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **10782**

BIRTH NO. FILED **APR 7 1954** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **773**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY OR TOWN EUREKA Mo.		c. CITY OR TOWN EUREKA	
c. LENGTH OF STAY (in this place) 5 YEARS		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 220 BIRCH TIMES BEACH		e. STREET ADDRESS (If rural, give location) 220 BIRCH TIMES BEACH	

3. NAME OF DECEASED (Type or Print) a. (First) ALMA b. (Middle) - c. (Last) LUPBERGER	4. DATE OF DEATH (Month) (Day) (Year) MAR. 25 1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Sept 17 1892	9. AGE (In years last birthday) 61	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) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.			

13a. FATHER'S NAME AUGUST BIERMAN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE ALBERT LUPBERGER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ALBERT LUPBERGER ADDRESS EUREKA Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) Hypertension		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <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 **May 1950**, to **3-25 1954**, that I last saw the deceased alive on **3-25-1954**, and that death occurred at **8:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph C. Carney MD	23b. ADDRESS 906 Olive	23c. DATE SIGNED 3-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR 29 1954	24c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO., Mo
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DATE REC'D BY LOCAL REG. 3/29/54	REGISTRAR'S SIGNATURE Harold B. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Rutis ADDRESS 2906 Garrison
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 500
10-58

Country

50 0198

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.....
Lawrence C. Hill

Licensed Embalmer No. *434*

P. O. Address *2906*

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.