

No. 300
10-46

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14449**
Registrar's No. **904**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY OR TOWN Shrewsbury		c. CITY OR TOWN Shrewsbury	
c. LENGTH OF STAY (in this place) 47 Yrs.		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: 7720 Suffolk Ave.		e. STREET ADDRESS (If rural, give location) 7720 Suffolk Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) B.	c. (Last) ACKFELD	4. DATE OF DEATH (Month) (Day) (Year) Apr. 15 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 16, 1871	9. AGE (In years last birthday) 82	# UNDER 1 YEAR	# UNDER 2 RES. HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Dealer (Retired)	10b. KIND OF BUSINESS OR INDUSTRY For Self	11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME HENRY ACKFELD	13b. MOTHER'S MAIDEN NAME ELIZABETH DREXEL	14. NAME OF HUSBAND OR WIFE Anna M. Ackfeld
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Anna M. Ackfeld	ADDRESS 7720 Suffolk Ave.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Vascular Disease		
	DUE TO (b) Cerebro-vascular accident with hemiplegia		
DUE TO (c)			
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 331X	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)
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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?
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22. I hereby certify that I attended the deceased from **Nov 27, 1942** to **Apr 15, 1954**; that I last saw the deceased alive on **Apr 15, 1954**, and that death occurred at **11:55P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Charles Westrup M.D.	(Degree or title) M.D.	23b. ADDRESS 204 E. Big Bend	23c. DATE SIGNED 4/16/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 19, 1954	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. 4-16-54	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	ADDRESS 4228 S. Kingshighway Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 .....
Licensed Embalmer No. 4537
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 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.