

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29784

State File No.

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 254

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY OR TOWN <u>Columbia</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>302 Westmount</u>		STREET ADDRESS (If rural, give location) <u>302 Westmount.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HERMANN</u>	b. (Middle) <u>B.</u>	c. (Last) <u>ALMSTEDT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 12, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 26, 1872</u>	9. AGE (in years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Prof. Germanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Laanguages U. of Mo.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Herman Almstedt</u>	13b. MOTHER'S MAIDEN NAME <u>Maria Laging</u>	14. NAME OF HUSBAND OR WIFE <u>Elizabeth Wilde Almstedt</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Franklin Launer, Columbia, Mo.</u>	ADDRESS _____
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anemia</u>		<u>1 week</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis</u>		<u>2 yrs.</u>
DUE TO (c) <u>Chronic Myocarditis</u>		<u>2 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture Left Femur</u>		<u>3 mo</u>	

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) _____
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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 Sept 2, 1954, to Sept 12, 1954, that I last saw the deceased alive on Sept 11, 1954, and that death occurred at 5:30A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Carl J. Dietrich MD</u> (Degree or title)	23b. ADDRESS <u>Prof. Pkly Columbia Mo</u>	23c. DATE SIGNED <u>Sept 13-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 14, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>Sept 14 1954</u>	REGISTRAR'S SIGNATURE <u>Miss RE Palmer 315</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parner Funeral Service, Columbia, Mo.</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

OCT 18 1954

OCT 19 1954

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..... *Thomas L. B...*

Licensed Embalmer No..... *4*

P. O. Address *Taluma*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.