

FILED FEB 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2268
Registrar's No. 0076

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) 3 days	c. CITY OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		STREET ADDRESS (If rural, give location) 2159 5524 So 37th	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) G c. (Last) Albers			4. DATE OF DEATH (Month) (Day) (Year) Jan 2, 1955		
5. SEX male <input checked="" type="radio"/>	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 15, 1879	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William G Albers	13b. MOTHER'S MAIDEN NAME Mary Gander	14. NAME OF HUSBAND OR WIFE Emma Albers
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 498-07-6151a	17. INFORMANT'S SIGNATURE OR NAME W Stanley Albers	ADDRESS 4138 Flad
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy.		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis, chronic		
	DUE TO (c) _____		
11. 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) 334X
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? _____

22. I hereby certify that I attended the deceased from 12:28, 1954, to 1:20, 1955, that I last saw the deceased alive on 1:20, 1955, and that death occurred at 1:20 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Eugene Vogel M.D.	23b. ADDRESS 3325 S Grand	23c. DATE SIGNED 1.4.55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/5/55	24c. NAME OF CEMETERY OR CREMATORY N St Marcus Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo
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DATE REC'D BY LOCAL REG. JAN 5 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

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 *Donald E. Berry*.....

Licensed Embalmer No. *485*

P. O. Address *7027 E*

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.