

FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER
258893
6342

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6342

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Overland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>3225 N. Florissant Little Sisters</u>			Length of stay in lb <u>6-yrs.</u>	d. STREET ADDRESS <u>8850 Burton Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Alge</u> Last <u>Alge</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1875</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR Month <u>8</u> Day <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waitress & Cashier-Scruggs</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Michael Alge</u>				14. MOTHER'S MAIDEN NAME <u>Agatha Diem</u>			
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. <u>488-10-7977</u>		17. INFORMANT Address <u>Mr. Theodore J. Mueller, 8850 Burton Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic seizure - decompensated myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis A.S.H.D.</u> DUE TO (c) <u>Epilepsy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 day</u> <u>???</u> <u>???</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>May 12, 1957</u> to <u>July 7, 1957</u> and last saw her alive on <u>July 6, 1957</u> Death occurred at <u>12:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.</u>							
22a. SIGNATURE (Type or print) <u>Bernard A. Howell, M.D.</u>				22b. ADDRESS <u>2435 N. Grand Blvd</u>		22c. DATE SIGNED <u>7-8-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 9, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		
24. FUNERAL DIRECTOR <u>Arthur J. Donnell</u>			ADDRESS <u>80 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 8 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>8.13.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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 W. J. Sayer....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. J. Sayer.....

Licensed Embalmer No. 469

P. O. Address 38 York

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