

FILED DEC 30 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

Registrar's No. 11744

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diagnoses in Part I must be causally related. USE ONLY Y-BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Florissant 4000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) Route 2 Box 493	
3. NAME OF DECEASED (Type or print) Sarah		4. DATE OF DEATH Month Day Year Dec. 5, 1957	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 28, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) St. Louis County, Mo	
13a. FATHER'S NAME Frank Niehaus		14. NAME OF HUSBAND OR WIFE Louis J. Albers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Address Louis Albers, R2 Box 493, Florissant, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic carcinoma of breast to cerebellum and liver. DUE TO (c) Generalized embolism. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Generalized embolism.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several months at least.	
20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at July 24, 57 9:45 PM to and last saw her alive on 4 Dec. 57 m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Jessie P. Schaefer, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec 9 1957	
23c. NAME OF CEMETERY OR CREMATORY Salem Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Black Jack, Missouri	
24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair		25. DATE RECD. BY LOCAL REG. DEC 6 57	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.		22c. DATE SIGNED 6 Dec. 57	

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 *Walter B. Burnley*

Licensed Embalmer No. *42820*

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.