

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025609

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7099**

STATE FILE NUMBER

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY - - -   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY - - -                                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>  |   | c. CITY OR TOWN <b>St. Louis</b>  |  |
| Length of stay in 1b<br><b>DOA</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>5932 Suson Pl.</b>  |  |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>William (n.m.i.) Altvater</b>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>July 6, 1963</b>  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-14-05</b>   |
| 9. AGE (last birthday)<br><b>58</b>  |   | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Office Manager</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wholesale Florist</b>   |  |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Henry Altvater</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Minnie Rohlfing</b>   |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>never married</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of<br><b>no</b> )  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mr. Albert Altvater</b>  |   | Address<br><b>7967 Birkenhead</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 weeks</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Coronary Artery Thrombosis</b>   |   |   | " " " " <b>1</b>   |
| DUE TO (c) <b>Coronary Atherosclerosis</b>   |   |   | <b>3 weeks</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>480.1</b>  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 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<br>Hour s.m. p.m.  | 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 <b>1-15-49</b> to <b>7-6-63</b> and last saw him alive on <b>6-28-63</b><br>Death occurred at <b>6:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><i>[Signature]</i>   |   | 22b. ADDRESS<br><b>634 M. Grand Blvd.</b>   |  |
| 22c. DATE SIGNED<br><b>7-8-63</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>7-9-63</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Our Redeemer</b>   |  |
| 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>HOFFMEISTER COLONIAL MORTUARY</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>SAM JUL 8 1963</b>   |  |
| 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |  |

USE BLACK INK OR TYPEWRITER RIBBON

Dr. James C. Murphy  
634 S. Grand  
JE. 1-1750  
PR. 1-6080

**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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.