

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029650

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7327**

STATE FILE NUMBER

FILED JUL 19 1963

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis U. Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1209 Wilmington Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		Month Day Year			
First		Middle		Last		Month		Day		Year	
Clementine		Albietz		Albietz		July		14th		1963	
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR	
Female		White				7-5-20		43		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beauty operator for self				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Unionville Mo.		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME Hallie Albee				13b. MOTHER'S MAIDEN NAME Erma Wyant				14. NAME OF HUSBAND OR WIFE Ernest Albietz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Ernest Albietz 1209 Wilmington Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Generalized Carcinomatosis											
DUE TO (b) Carcinoma Esigmoid											
DUE TO (c) 153.3											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? 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		Hour a.m. p.m.		Month, Day, Year							
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 Jan '63 to July 63 and last saw her alive on 13 July 63		Death occurred at 12:12 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Print or Type) <i>[Signature]</i>				22b. ADDRESS 3915 Watson				22c. DATE SIGNED 7/15/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-17-63		23c. NAME OF CEMETERY OR CREMATORY Resurrection		23d. LOCATION (City, town, or county) St. Louis County Mo.		23e. (State)			
24. FUNERAL DIRECTOR Kriegshauser 4228 So. Kingshighway				ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 16 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Dr. Dolan John T. 3915 Watson Rd - Mci-7-4221
Rt. 330 to Spem

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 James R. Quinn

Licensed Embalmer No. 4527

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.