

FILED JAN 23 1948

1003

Registration District No. _____ Primary Registration District No. _____

Registrar's No. **328**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Macoupin** **999**
 (c) City or town **Girard**
(If outside city or town limits, write "RURAL")
 (d) Street No. **806 W. Center**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) **2**
 If yes, name country _____

3. (a) PRINT FULL NAME **Alan Walter Adler**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Eunice Adler** 6. (c) Age of husband or wife if alive **30** years

7. Birth date of deceased **December 23 1911**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	35	0	15	_____ hr. _____ min.

9. Birthplace **St. Jacobs Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Signal Maintenance**

11. Industry or business **Alton R R**

12. Name **Walter Henry Adler**

13. Birthplace **Marine Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Alice Sohn**

15. Birthplace **St. Jacobs Twshp., Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Adler**

(b) Address **Girard, Ill.**

17. (a) **Removal** (b) Date thereof **1-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Girard, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JAN 8 1947** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **8**
 year **1947** hour _____ minute **45** **A.M.**

21. I hereby certify that I attended the deceased from **Jan - 1**
 19**47**, to **Jan 8**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Subeortical clot (At J)**
Subarachnoid hemorrhage
 Due to **Suba. Vascular**
 Due to **Sum -**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **Same**
 Of operations _____

Of autopsy **Same**

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
(Specify type of place) Means of injury _____

23. Signature **D. N. Blum** (M. D. or other) **M. D.**

Address **4952 Maryland Ave.** Date signed **1/8/47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Elmo R. Sadwell*

Licensed Embalmer No. *4077*

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 this body is not embalmed, fact should be so stated above.