

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

100-6-17-30 I X1951

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 784 Primary Registration District No. 116 Registrar's No. 424

1. PLACE OF DEATH
(a) County ST LOUIS
(b) City or town VALLEY PARK (R)
(c) Name of hospital or institution HOME 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 1 year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS
(c) City or town VALLEY PARK (R) 135
(If outside city or town limits, write "RURAL")
(d) Street No. HAWKINS ROAD
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years

3. (a) PRINT FULL NAME ALOIS FOHRMANN
(b) If veteran, name war NO
(c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 2 day 24
year 1941 hour 7 minute - A M.

4. Sex MALE
5. Color of race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased MAY 3 1896
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 15 1940 to Feb 24 1941
that I last saw him alive on Feb 22 1941
and that death occurred on the date and hour stated above.
Immediate cause of death Tuberculosis
Duration uncertain

8. AGE: Years 44 Months 9 Days 21
If less than one day hr. min.
9. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)
10. Usual occupation MINER

Due to Sclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

11. Industry or business
MOTHER FATHER { 12. Name WALTER FOHRMANN
13. Birthplace UNKNOWN GERMANY
14. Maiden name FRANCES KUSTER
15. Birthplace UNKNOWN GERMANY
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Frank Burkert
(b) Address Valley Park MO RI
17. (a) Burial (b) Date thereof Feb 24 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Pauls Cemetery
18. (a) Signature of funeral director
(b) Address Fulton, MO
19. (a) FEB 24 1941 (Date received local registrar)
(b) Registrar's signature

22. If death was due to external causes, fill in the following:
(a) 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)
(e) Means of injury
23. Signature Clara M. Gebert (M. D. or other)
Address Valley Park, Mo Date signed 2/24/41

12/2/1

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 Kenneth W. Koch
Licensed Embalmer No. 3047
P. O. Address Fenton, Mo.

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8225

Registration District No. 784

Primary Registration District No. 116

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Valley Park
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alois Fuchsmann

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 24
year 1941 hour _____ minute _____ M.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis *Duration*

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

44 9 21

Due to Silicosis # N. M. D. #
Chronic miner - Indefinite

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) 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)

(e) Means of injury _____

23. Signature Clara M. Gehert (M. D. or other) MD

Address Valley Park Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

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.....

Licensed Embalmer No.....

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.