

FILED OCT 28 1942

Registration District No.

Primary Registration District No. **1003**

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:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... **5 weeks**
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Missouri** (b) County... **Ste. Genevieve**
(c) City or town... **Ste. Genevieve**
(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 **Edward Joseph Falk**

3. (b) If veteran, name war..... 3. (c) Social Security No. **492-10-7031**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **10/18/42** day **18** year **1942** hour **1:20** minute **P** M.
21. I hereby certify that I attended the deceased from **8/15/42**, 19, to **10/18/42**, 19, that I last saw him alive on **10/18/42**, 19, and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or 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..... years

7. Birth date of deceased **Oct. 2nd 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 0 16 hr. min.

9. Birthplace **Ste. Genevieve, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Lumber Man**

11. Industry or business.....

12. Name **Francis Falk**

13. Birthplace **Mascoutah, Ill.**
(City, town, or county) (State or foreign country)

14. Maiden name **Theika Deck**

15. Birthplace **Baden City, Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Winnebert Falk**

(b) Address **Bunker, Mo.**

17. (a) **Burial** (b) Date thereof **10-20-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ste. Genevieve, Mo.**

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

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

19. (b) **19 1942** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

Duration
Immediate cause of death **Cerebral occlusion**
Due to **1 day**
Due to **arterio sclerosis**
Other conditions **arterio sclerosis**
(Include pregnancy within 3 months of death)
Major findings:
Of operations **4/1**
Of autopsy.....
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) (c) Means of injury.....

23. Signature **[Signature]** (M. D. or other)
Address **[Signature]** Date signed **10/19/42**

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.....

Albert G. Hoffa

Licensed Embalmer No..... 2971

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.