

S. No. 2  
M-5-43  
7-5-17-39  
I X36671

FILED NOV 30 1944  
Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **9764**

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

**1. PLACE OF DEATH:**  
 (a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Bethesda General Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo. (b) County W  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3819 Russell  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Baby Follenmeier  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** F **5. Color or race** W  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if**  
 \_\_\_\_\_ **alive** \_\_\_\_\_ years  
**7. Birth date of deceased** 11 14 44  
 (Month) (Day) (Year)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day  
18 hr. 40 min.

**9. Birthplace** St. Louis, Mo.  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**  
**12. Name** Rudolph Follenmeier  
**13. Birthplace** GERMANY  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** Clara Heide  
**15. Birthplace** South Germany  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** Rudolph Follenmeier

**(b) Address** 3819 Russell

**17. (a) Place** Burial **(b) Date thereof** Nov 17 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**18. (a) Signature of funeral director** Wreck Cox

**(b) Address** 2201 S. Grand St.

**19. (a) Date received local registrar** NOV 17 1944 **(b) Registrar's signature** J. J. Bredeck

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month 11 day 16  
 year 1944 hour 7 minute 2 M.  
**21. I hereby certify that I attended the deceased from** 11-14-44, 19\_\_\_\_, to 11-16-44, 19\_\_\_\_;  
 that I last saw her alive on 11-16-44, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** Pericardial thrombosis **Duration** 24-h  
**Due to** atherosclerosis  
**Due to** Arteriosclerosis

**Other conditions** \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

**Major findings:** 159  
**Of operations** \_\_\_\_\_  
**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** J. J. Bredeck **(M.D. or other)** MD  
**Address** 4600 Maryland **Date signed** 11-16-44

---

**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

*Waring A. Stewart*

Licensed Embalmer No.

*3722*

P. O. Address

*412 Duchangville*

**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.**