

S. No. 2
DM-5-43
v. 5-137
I X36671

FILED FEB 24 1945 **318**

1003

Registration District No. _____ Primary Registration District No. _____

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 **O**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ? (Specify whether Life)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis **96**

(c) City or town St. Louis Jennings **N.R.**
(If outside city or town limits, write "RURAL")

(d) Street No. 2445 Hord Ave. Jennings.
(If rural, give location)

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

3. (a) PRINT FULL NAME Lydia Falkenrath

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed **2**

6. (b) Name of husband or wife Julius Falkenrath alive _____ years

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

7. Birth date of deceased November 15, 1867.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>2</u>	<u>25</u>	hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Henry C. Ellerbrock **4**

13. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Paust **4**

15. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

16. (a) Informant C. J. Falkenrath

(b) Address 28 Enfield Rd. Clayton.

17. (a) Burial (b) Date thereof Feb. 13, 1945.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home

(b) Address 4828 Natural Bridge B. lvd.

19. (a) FEB 13 1945 (b) J. F. Bruesch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10th
year 1945 hour 3:30 minute A. M.

21. I hereby certify that I attended the deceased from 2-9-45, 19____, to 2-10-45, 19____;
that I last saw h. 3 alive on 2-10-45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Degeneration Myocarditis

Due to hypertension

Due to hypertension ch. 4

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

Major findings: 1/21

Of operations _____

Of autopsy _____

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 R. K. Anderson (M. D. or other) **O**

Address 4932 Maywood Date signed 2/12-45

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

0
7
9

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 *Ronald J. Yahrke*.....

Licensed Embalmer No. *3917*.....

P. O. Address *St. Louis, 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, fact should be so stated above.