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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 11 1945

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18069

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 3070

Registrar's No. 1315

1. PLACE OF DEATH: St. Louis:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
810 Newport Ave  
(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 Missouri (b) County St. Louis

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

(d) Street No. 810 Newport Ave  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Arthur Falkenhainer

3. (b) If veteran, name war \*\*\*\*\*

3. (c) Social Security No. \*\*\*\*\*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5<sup>th</sup>  
year 1945 hour 10:30 minute P M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Paula Falkenhainer

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased January 7 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 12 - 1943 to June 5 - 1945 that I last saw him alive on June 2 - 1945 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>4</u>	<u>0</u>	hr. min.

Immediate cause of death Cerebral Tuberculosis and again 2 1/2 yrs.

Cerebral Tuberculosis 2 days

Due to Cerebral Tuberculosis 93d 3 years.

Other conditions Hypertrophy of prostate

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

10. Usual occupation Merchant Retired

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name Melchior Falkenhainer

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

14. Maiden name Marie Briett

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

16. (a) Informant Paula Falkenhainer

(b) Address 810 Newport Ave

17. (a) Cremation (b) Date thereof June 8 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Ernestine Bloo

(b) Address 6409 Gravois Ave

19. (a) JUN 8 1945 (b) ETG. McCann  
(Date received local health officer's report) (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 H. O. Ashford (M. D. or other) \_\_\_\_\_

Address 19 E. Lafayette Date signed 6/6/45

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

**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..... *Homer W. Jutz* .....

Licensed Embalmer No. *3882* .....

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.**