No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15072

FILED MAY 9 1947

Registration District No. #48657 318 Primary Registration District No. 1003 Registrar's No. 2195

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital, Max Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Memorial (Specify whether In this community 19 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 1114 Victor (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ~~BABY (MALE)~~ Infant FOELSCH

3. (b) If veteran, name war

3. (c) Social Security No.

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 4-2-47 (Month) (Day) (Year)

8. AGE: Years | Months | Days 19 | ~~If less than one day~~ 2 hr. 46 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Floyd Harold Foelsch
13. Birthplace Jacksonville, (City, town, or county) Ill. (State or foreign country)

MOTHER
14. Maiden name Mae Kagle
15. Birthplace Corning, (City, town, or county) Ark. (State or foreign country)

16. (a) Informant Floyd H. Foelsch
(b) Address 1114 Victor

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 5-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutgers

19. (a) MAY 2 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21 year 1947 hour 2:45 minute P M.

21. I hereby certify that I attended the deceased from 4-2-47, 19..., to 4-21-47, 19...; that I last saw him alive on 4-21-47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: aspiration of feeding Premature Infant

Due to: Had had diarrhea which

Due to: had apparently stopped.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature S W Follett (M. D. or other)

Address 1515 Lafayette Date signed 4-21-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.