

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 25 1955

38240

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9640**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>	c. LENGTH OF STAY (in this place) <b>1 WK</b>	c. CITY OR TOWN <b>St Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Anthony Hospital</b>		STREET ADDRESS (If rural, give location) <b>1361 McCutcheon</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Waldo</b>	b. (Middle) <b>W</b>	c. (Last) <b>Foreman Sr.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 4, 1955</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Feb 28, 1886</b>	9. AGE (In years last birthday) <b>69</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Bernard Forsman</b>	13b. MOTHER'S MAIDEN NAME <b>Schaeffner</b>	14. NAME OF HUSBAND OR WIFE <b>Olga Forsman</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY <b>494-09-9993A</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dr W W Foreman</b> ADDRESS <b>9505 Gravois</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11-3-55** to **11-4-55**, that I last saw the deceased alive on **11-4-55**, and that death occurred at **5:00A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Raymond T. Martin</b> (Degree or title)	23b. ADDRESS <b>5203 Clay</b>	23c. DATE SIGNED <b>11-4-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11/7/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	24d. LOCATION (City, town, or county) (State) <b>Affton Mo</b>
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DATE REC'D BY LOCAL REG. <b>NOV 5 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J L Ziegenhein &amp; Sons</b> ADDRESS <b>7027 Gravois</b>
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WRITE PLAINLY—USING 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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Donald E Benz*

Licensed Embalmer No. *496*

P. O. Address *7027*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.