

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-033797

### FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-7389**

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 weeks</b>	c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1444 Wachtel ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>J.</b> Last <b>Folkemer</b>			4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1959</b>		
---------------------------------------------------------------------------------------------------	--	--	------------------------------------------------------------------------	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1910</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------	-------------------------------------	--------------------------------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Big 4 Chev. Co.</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
-----------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

13a. FATHER'S NAME <b>Joseph A. Folkemer</b>	13b. MOTHER'S MAIDEN NAME <b>Teresa Marie Karbach</b>	14. NAME OF HUSBAND OR WIFE <b>Norma</b>
-------------------------------------------------	----------------------------------------------------------	---------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>Norma Folkemer</b> Address <b>1444 Wachtel ave. Lemay,</b>
-----------------------------------------------------------------------------------------------------------------------	----------------------------------	--------------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Splenomegaly</b>	
	DUE TO (c) <b>581.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Splenomegaly &amp; Ascites</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------------

21. I attended the deceased from <b>8-17-49</b> to <b>8-23-57</b> and last saw him alive on <b>8-28-57</b> Death occurred at <b>8.45 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE (Degree or title) <b>Bert Klein M.D. &amp; O.D. M.D.</b>	22b. ADDRESS <b>2632 S. Kings Highway</b>	22c. DATE SIGNED <b>8-25-59</b>
----------------------------------------------------------------------------	----------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug. 26, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Rd. Lemay, Mo.</b>
-------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------	-----------------------------------------------------------------------------------------

24. GENERAL DIRECTOR'S ADDRESS <b>C. Hornelster Mortuaries 7814 S. Broadway</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 24 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith. M.D.</b>
----------------------------------------------------------------------------------------	---------------------------------------------------	-------------------------------------------------------

RECEIVED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 John S. Bennett

Licensed Embalmer No. 4194

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.