

# JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033798

FILED VS. SEP 16 1959  
 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8060**

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hosp.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>  c. CITY OR TOWN <b>Afton</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS <b>9000 South View Dr.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry H Folkerth</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>Aug. 29, 1959</b> Month Day Year					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/27/14</b>	<b>9. AGE (last birthday)</b> <b>45</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bus Operator</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Public Service</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>			
<b>13a. FATHER'S NAME</b> <b>Harry H Folkerth</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Nina Baldwin</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Margaret Folkerth</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>				<b>16. SOCIAL SECURITY NO.</b> <b>497-07-3472</b>		<b>17. INFORMANT</b> Address <b>Margaret Folkerth 9000 South View Dr.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lymphoblastic Leukemia</b> DUE TO (b) <b>204.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 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						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 years</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>Jan 1955</u> to <u>8-29-59</u> and last saw <sup>her</sup> him alive on <u>8-29-59</u> Death occurred at <u>8:35P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> <i>Carol J. [Signature]</i> (Degree or title) <b>M.D.</b>				<b>22b. ADDRESS</b> <i>St. Louis, Mo 1801 Kingshighway</i>		<b>22c. DATE SIGNED</b> <b>8-31-59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>9/1/59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cem.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Jefferson Bks. Mo</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Edward Fendler 5611 South Grand Blvd.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 31 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Paul Smith, M.D.</i> m 86			

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 T. A. Humphrey

Licensed Embalmer No. 4772

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