

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

FILED VS MAY 23 1960

318

Primary Registration District No. 1003

Registrar's No.

4681

=60-021230

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		a. STATE Mo. b. COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp.		c. CITY OR TOWN Richmond Heights	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3104 Delnorte	
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Harriet Ludwig			4. DATE OF DEATH Month Day Year May 2, 1960			
--	--	--	---	--	--	--

5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1911	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
------------------	---------------------------	---	-----------------------------------	------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk, Secy.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	--	------------------------------------

13a. FATHER'S NAME John L. Helm	13b. MOTHER'S MAIDEN NAME Carrie Mueller	14. NAME OF HUSBAND OR WIFE Julius Ludwig
------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 498-16-8532	17. INFORMANT Mond Heights, Mo. Julius Ludwig 3104 Delnorte, Rich-
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute monocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH about 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 2042 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) none
---	---	--

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 4/11/59 to 5/2/60 and last saw her/him alive on 5/1/60

Death occurred at 5:20 am on the date stated above, and to the best of my knowledge, from the causes stated.		
--	--	--

22a. SIGNATURE <i>W. J. ...</i>	(Degree or title)	22b. ADDRESS 3804 Wilington Ave	22c. DATE SIGNED 5/3/60
------------------------------------	-------------------	------------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5-5-60	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) Lemay, Mo.
---	---------------------	--	---

24. FUNERAL DIRECTOR Southern Funeral Home 6322 S. Grand, St. Louis, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. MAY 3 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	---------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. W. J. W. W.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *David Van Fossan*

Licensed Embalmer No. 4242

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.