

**FEDERAL BUREAU OF INVESTIGATION
FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-60-039386

FILED VS NOV 1 1960

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 215

ENDED

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>St. Charles,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>730 N. 6th.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>William</u> Last <u>Ahlemeyer</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22/84</u>		9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel-worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ACF Industries</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Wilhelm Ahlemeyer</u>				13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Flesch</u>				14. NAME OF HUSBAND OR WIFE <u>Victoria C. Ahlemeyer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>498-07-6545</u>		17. INFORMANT Address <u>Carl V. Ahlemeyer, St. Charles, M</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH HAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>										Unknown			
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					
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.) _____									
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 <u>October 23, 1960</u> to <u>October 24, 1960</u> and last saw him alive on <u>October 24, 1960</u> Death occurred at <u>1:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Don J. Randall, M.D.</u>				22b. ADDRESS <u>220 S. 6th St. Charles, Mo.</u>				22c. DATE SIGNED <u>Oct 26, 1960</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 27, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>							
24. FUNERAL DIRECTOR <u>Arthur C. Baue, St. Charles, Mo.</u>				ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>Oct 27-60</u>		26. REGISTRAR'S SIGNATURE <u>Marella Wilson</u>					

(Licensed Embalmer's Statement on Reverse Side)

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David C. Rose

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.