S. No. 2
—11-10-39
5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19931 4879

FILED JUL 17 1940

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days) FERDINAND 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Randlph

(c) City or town Sparta N.R.
(If outside city or town limits write "RURAL")

(d) Street No. 615 E. Broadway
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ~~FREIDMAN~~ GODFREID FALKENHEIM

3. (b) If veteran, name war World War

3. (c) Social Security No. 702-16-6742

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March (Month) 23 (Day) 1895 (Year)

8. AGE: Years 45 Months 2 Days 8 If less than one day hr. min.

9. Birthplace Baldwin (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Mo. Pacific R.R.

FATHER 12. Name Fred Falkenheim

FATHER 13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER 14. Maiden name Kate Stahlman

MOTHER 15. Birthplace (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs. Emma Falkenheim

(b) Address 615 E. Broadway Sparta, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-3-40 (Month) (Day) (Year)

(c) Place: burial or cremation Sparta, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUN 3 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd year 1940 hour 4:20 minute P. M.

21. I hereby certify that I attended the deceased from May 19th, 1940, to June 2nd, 1940, that I last saw him alive on June 2nd, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Septicemia	1 wk
Due to Staphylococcus albus	
Due to	
Other conditions Cerebral thrombosis, c left hemiplegia caused	
Major findings Of operations by cerebral thrombosis	
Of autopsy —	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Malvern T. Bryan (M. D. or other)

Address Mo. Pac. Hosp. St. Louis Date signed 6/2/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2471

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.