

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

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1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Facility  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. May 6, 1942  
(Specify whether years, months or days)

In this community Unknown.

8. (a) PRINT FULL NAME Emil FURER,

3. (b) If veteran, name war World War 1918

3. (c) Social Security No. 498-03-1228

4. Sex Male ( ) race White

5. Color or race White

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

6. (b) Name of husband or wife Henrietta

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased April 14, 1892  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>0</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Bartender.

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name: Unavailable

13. Birthplace: Unavailable  
(City, town, or county) (State or foreign country)

14. Maiden name: Unavailable

15. Birthplace: Unavailable  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schellig

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Burial (b) Date thereof May 9, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. Jeff. Bks.

18. (a) Signature of funeral director Joseph M. Kullmiller

(b) Address 6203 Gravois

19. (a) MAY 8 - 1942 (b) E. M. Mc Laron  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town Saint Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2000 Shenandoah  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th.  
year 1942 hour 1:10 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from May 6, 1942 to May 6, 1942  
that I last saw him alive on May 6, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive and metabolic (obesity) heart disease, myocardial damage and myocardial insufficiency.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: See cause of death above

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

(a) Accident, suicide, or homicide (specify) NO

(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)

23. Signature L. M. COCHRAN, M.D., (M. D. or other) \_\_\_\_\_  
Address Chief Medical Officer Date signed 5/6/42.

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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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 *W. Wilkerson*

Licensed Embalmer No. 3575

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