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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8934
Registrar's No. 2640

FILED MAR 27 1944

318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 3 days (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1007 Allen Ave.
(If rural, give location)
(e) Citizen of foreign country?..... no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... Elizabeth Folk
(b) If veteran, name war..... XX
(c) Social Security No. XX

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 16th
year..... 1944 hour 4:50 minute..... P.M.
21. I hereby certify that I attended the deceased from..... March 13th
....., 19 44 to..... March 16th, 19 44

4. Sex Female 5. Color or race..... White
6. (a) Single, widowed, married, 2 divorced Widowed
6. (b) Name of husband or wife..... Martin Folk
6. (c) Age of husband or wife if alive..... XX years
7. Birth date of deceased..... October 19 1865
(Month) (Day) (Year)

that I last saw h..... im alive on..... March 16th, 19 44
and that death occurred on the date and hour stated above.
Immediate cause of death..... Carcinoma of Cecum
& Metastasis to Liver
Duration
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy..... C. Cecum & Metastasis to Liver

8. AGE: Years Months Days If less than one day
78 4 27 hr. min.
9. Birthplace..... Hungary 4
(City, town, or county) (State or foreign country)
10. Usual occupation..... at home

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 place of place)
(a) Means of injury.....

MOTHER FATHER
11. Industry or business..... -- Kierer
12. Name.....
13. Birthplace..... Hungary 4
(City, town, or county) (State or foreign country)
14. Maiden name..... Katie Hirsch
15. Birthplace..... Hungary 4
(City, town, or county) (State or foreign country)

23. Signature..... [Signature] (M. D. or other)
Address..... 1515 Lafayette Date signed..... 3/16/44

16. (a) Informant..... John Kalch
(b) Address..... 5111 Cologne Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof..... 3/20/1944
(Month) (Day) (Year)
(c) Place: burial or cremation..... Old S.S. Peter & Paul
18. (a) Signature of funeral director..... John S. Ziegenfuss & Sons
(b) Address..... 7027 Gravois Ave.
19. (a) MAR 20 1944 (Date received local registrar)
J. L. Bruders (Registrar's signature)

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

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.....

C. P. Kidwell

Licensed Embalmer No.....

3877

P. O. Address.....

7027 Biavais

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, fact should be so stated above.