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#38225
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4228
State File No. _____
Registrar's No. **1085**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County W. 13
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2017 Edwards St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clemens Foppe
3. (b) If veteran, name war no
3. (c) Social Security No. 493-09-4008

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Catherine Foppe
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased November 30, 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 2 1 hr. min.

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

10. Usual occupation Moulder
11. Industry or business McQuay-Norris

MOTHER FATHER
12. Name Clemens Foppe
13. Birthplace Carlisle, Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Mary Kerkenmeyer
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Foppe
(b) Address 2017 Edwards St.

17. (a) Burial (b) Date thereof 2-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New SS. Peter & Paul

18. (a) Signature of funeral director Paul C. Calcaterra
5142 Daggett Ave
(b) Address

19. (a) FEB 2 1945 (b) J. F. Bedeck
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 1st
year 1945 hour 6:35 minute P. M.
21. I hereby certify that I attended the deceased from 1/30/45
_____, 19____, to 2/1/45, 19____;
that I last saw him alive on 2/1/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Duration 8 days

Due to _____
Due to 108
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy None performed
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? _____

(Specify type of place) (c) Means of injury
While at work? _____
23. Signature E. W. Czebunich (M. D. or other) _____
Address 1515 Lafayette 2/1/45 date signed

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.....

Raul C. Carlatina

Licensed Embalmer No. 2376

P. O. Address 5172 Dwight

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.